SUBCHAPTER T. MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT POLICIES
28 TAC §3.3312

1. INTRODUCTION. The Texas Department of Insurance proposes amendments to 28 TAC §3.3312, concerning the guaranteed issuance of Medicare supplement coverage to certain enrollees of the Texas Health Insurance Pool. Amendments to §3.3312 are necessary to provide a guaranteed issue opportunity for alternative coverage for Medicare enrollees whose secondary Pool coverage is terminating as a result of the coming dissolution of the Pool, and to conform with agency style and usage guidelines.

The amendments to §3.3312 provide a guaranteed issue opportunity for Pool enrollees concurrently enrolled in Medicare, because those Pool enrollees are unable to obtain new supplemental coverage when their Pool coverage ceases. These enrollees are predominantly under the age of 65 and have qualified for pre-65 Medicare coverage due to disabilities or end stage renal disease. They purchased Pool coverage to pay claims secondary to Medicare because of the high claims costs that are not paid by Medicare, and because the Pool generally provides more benefits than Medicare supplement products. When they purchased Pool coverage, they could not have known that the Pool would be terminated, and they have now lost their initial guaranteed issue opportunity to purchase Medicare supplement insurance, a narrow window of time during which they initially enrolled in Medicare Part B.

The department originally adopted §3.3312 to provide for additional Medicare supplement guaranteed issue opportunities for those on Medicare, such as for those whose group health insurance coverage is terminated (§3.3312(b)(1)), but the department did not anticipate that Pool enrollees would need such a special enrollment opportunity. To give those with Pool coverage the same opportunity to enroll in Medicare supplement coverage as those with employer-sponsored coverage, the department proposes to add amendments to §3.3312 to require that Medicare supplement carriers treat those whose Pool coverage is being terminated as eligible to purchase a Medicare Supplement policy for 63 days from the termination of their Pool coverage.

The department proposes to add subsection (b)(9) to §3.3312 to identify those losing their Pool coverage as eligible persons.

The department proposes to amend section §3.3312(c)(1) to identify the Medicare supplement policies that former Pool enrollees may purchase on a guaranteed issue basis.

The department proposes to add subsection (d)(7) to §3.3312 to specify the guaranteed issue time period, 63 days from the date of the termination of Pool coverage.

The department proposes non-substantive amendments to other parts of §3.3312 to conform with agency style and usage guidelines.

2. FISCAL NOTE. Jan Graeber, director and chief actuary, Rate and Form Review Office, in the Life, Accident, and Health Section, has determined that for each year of the first five years the proposed sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

3. PUBLIC BENEFIT AND COST NOTE. Ms. Graeber has also determined that for each year of the first five years the proposed sections are in effect, the public benefit anticipated as a result of the proposal is a new availability of alternative supplemental coverage options for Pool enrollees currently in Medicare.

The cost to persons required to comply with the proposal is related to the requirement of the rule that termination of Pool coverage qualifies as a guaranteed issue opportunity for Medicare supplement coverage.

There are approximately 550 Pool enrollees currently on Medicare. On average, the Pool pays approximately $10,000 per year for claims on each enrollee for which it pays secondary to Medicare. The department anticipates that Medicare supplement coverage generally would pay a lower amount. Ms. Graeber anticipates that the cost of the proposed amendments to §3.3312 will be no more than approximately $5,500,000

per year, spread across the Medicare supplement carriers that the Pool enrollees choose, less the premium paid for the new Medicare supplement policies issued.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. Government Code §2006.002(c) provides that if a proposed rule may have an economic impact on small businesses, state agencies must prepare as part of the rulemaking process an economic impact statement that assesses the potential impact of the proposed rule on small businesses and a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the rule. Government Code §2006.001(2) defines "small business" as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit; is independently owned and operated; and has fewer than 100 employees or less than $6 million in annual gross receipts. Government Code §2006.001(1) defines a "micro business" as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit; is independently owned and operated; and has not more than 20 employees. Government Code §2006.002(f) requires a state agency to adopt provisions concerning micro businesses that are uniform with those provisions outlined in Government Code §2006.002(b) - (d) for small businesses.

As required by Government Code §2006.002(c), the department has determined that amendments to §3.3312 may have an adverse economic impact on small and micro businesses that are issuers of Medicare supplement policies in Texas under Insurance

Code Chapter 1652. The department has determined that approximately 47 carriers are currently offering coverage in the under age 65 Medicare supplement market. The department believes that one or more of these carriers is a small or micro business under Government Code §2006.002(c). The adverse economic impact of the proposal on these carriers results from the costs associated with the requirement to issue Medicare supplement insurance policies to applicable Pool enrollees, as discussed in the Public Benefit and Cost Note, above. The costs will vary for small and large businesses based on the number of Pool enrollees each carrier enrolls.

The department has considered exempting small and micro business carriers from the requirements of this rule proposal but has concerns about the feasibility of such an exemption and the potential for consumer confusion. Carriers currently do not regularly specifically report their small or micro business status to the department. Thus, at any given time, the department would not be able to tell consumers which carriers would be exempt from the rule. A consumer would likely only know if a carrier was exempt from the guaranteed issuance requirement of the proposed rule if the consumer applied and was refused on that basis. This could result in confusion on the part of consumers with serious medical conditions and complaints against the carriers denying coverage. Further, the purpose of the applicable Medicare supplement statutes is to make that coverage available in Texas, and exempting some carriers from the rule will narrow the coverage options available to these consumers.

Even without an exemption, the department anticipates that small or micro business carriers will not be forced to accept an unreasonable number of former Pool enrollees, as buying decisions are often made on the basis of factors such as premium cost, unrelated to the size of the carrier. Additionally, all carriers will be able to file future rate increase requests in light of any increased risk they incur due to the proposed rule.

For these reasons, the department has not included an exemption for small and micro business carriers in the current proposal. However, the department is interested in receiving comments on this issue. Those commenting in favor of an exemption should consider discussing in as much detail as possible the benefit of such an exemption to small and micro business carriers, the potential harm to small and micro business carriers of not receiving an exemption, the anticipated impact of such an exemption on the other carriers in the market and on the availability of coverage, any potential lesser exemptions other than a blanket exemption, and potential methods for the department and the public to identify those carriers claiming the exemption.

5. TAKINGS IMPACT ASSESSMENT. The department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and so does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

6. REQUEST FOR PUBLIC COMMENT. If you wish to comment on this proposal you must do so in writing no later than 5 p.m. on January 27, 2014, to Sara Waitt, general counsel, by email at chiefclerk@tdi.texas.gov, or by mail at Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. You must simultaneously submit an additional copy of the comments to Jan Graeber, director and chief actuary, Rate and Form Review Office, by email at lhlcomments@tdi.texas.gov or by mail at Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

The commissioner will consider the adoption of the proposed amendments in a public hearing under Docket No. 2761 scheduled for 9 a.m. on January 23, 2014, in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. Written and oral comments presented at the hearing will be considered.

7. STATUTORY AUTHORITY. The department proposes the amendments under Insurance Code §§36.001, 1506.005, 1652.005, and 1652.051.

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.

Section 1506.005 provides that the commissioner may adopt rules necessary and proper to implement Chapter 1506 (relating to the Health Insurance Pool).

Section 1652.005 provides that the commissioner must adopt reasonable rules necessary and proper to carry out Chapter 1652 (relating to Medicare Supplement Benefit Plans).

Section 1652.051 provides that the commissioner must adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans.

8. CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal:

§3.3312 Insurance Code Chapter 1506

§3.3312 Insurance Code Chapter 1652

9. TEXT.

§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 must [~~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 must [~~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 must [~~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 the [~~such~~] provider if the [~~such~~] individual were enrolled in a Medicare Advantage plan:

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

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

(C) the[~~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[~~The~~] individual demonstrates, in accord [~~accordance~~] with guidelines established by the Secretary, that:

(i) the[~~The~~] organization offering the plan substantially violated a material provision of the organization's contract under 42 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 the[~~such~~] covered care in accord [~~accordance~~] with applicable quality standards; or

(ii) the[~~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[~~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[~~An~~] eligible organization under a contract under §[~~section~~]1876 of the Social Security Act (Medicare cost);

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

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

(D) an [~~An~~] organization under a Medicare Select policy; and

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

(A) of[~~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[~~The~~] issuer of the policy substantially violated a material provision of the policy; or

(C) the[~~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[~~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 the[~~such~~] subsequent enrollment (during which time the individual is permitted to terminate the[~~such~~] subsequent enrollment under §[~~section~~]1851(e) of the Social Security Act); or

(6) the[~~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 Title XIX of the Social Security Act (Medicaid).

(9) The individual meets the following requirements:

(A) the individual was enrolled in both the federal Medicare program and the Texas Health Insurance Pool on December 31, 2013; and

(B) the individual's Pool coverage terminated on or after December 31, 2013.

(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), (8), and (9) [~~and~~] 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 must [~~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 [~~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 63 [~~sixty-three (63)~~] days later[~~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 63 [~~sixty-three (63)~~] days later[~~thereafter~~].

(2) in[~~In~~] the case of an individual described in subsection (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[~~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[~~In~~] the case of an individual described in subsection (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[~~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 under § [~~pursuant to Section~~]1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day [~~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[~~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; and[.]

(7) in the case of an individual described in subsection (b)(9) of this section, the guaranteed issue period begins on the date that the individual's coverage in the Texas Health Insurance Pool terminates and ends 63 days later.

(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, under [pursuant to] this paragraph), whose enrollment with an organization or provider described in subsection (b)(5) of this section 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 will [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, under [pursuant to] this paragraph), whose enrollment with a plan or in a program described in subsection (b)(6) of this section 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 will [shall] be deemed to be an initial enrollment as described in subsection (b)(6) of this section.

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

section, may be deemed to be an initial enrollment under this paragraph after the 2-year [~~2 – year~~] period beginning on the date on which the individual first enrolled with the[~~such an~~] organization, provider, plan, or program.

10. CERTIFICATION. This agency certifies that legal counsel has reviewed the proposal and found it to be within the agency's legal authority to adopt.

Issued at Austin, Texas, on December 12, 2013.

Sara Waitt
General Counsel
Texas Department of Insurance