Subchapter T. Minimum Standards for Medicare Supplement Policies
28 TAC §§3.3309, 3.3312, and 3.3324

INTRODUCTION. The commissioner of insurance adopts amendments to 28 TAC §§3.3309, 3.3312, and 3.3324, concerning requirements for Medicare supplement coverage. The amendments are adopted with one change to the proposed text published in the May 15, 2026 issue of the *Texas Register* (51 TexReg 3306).

REASONED JUSTIFICATION. The amendments to §§3.3309, 3.3312, and 3.3324 are necessary to implement House Bill 2516, 89th Legislature, 2025, which added Insurance Code §1652.059 and §1652.060, requiring that individuals younger than 65 who become enrolled in Medicare by reason of end stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS) be given access to the same coverage, and in some cases at the same rates, as those offered to individuals 65 and older. The amendments also clarify the existing language and protections regarding guaranteed issuance and the rating of disabled enrollees when they turn 65, which were discussed in Commissioner's Bulletin #B-0027-21 (October 1, 2021) (available online at www.tdi.texas.gov/bulletins/2021/B-0027-21.html).

Descriptions of the sections' amendments follow.

Section 3.3309. Amendments to subsection (a)(1) remove language from subparagraphs (D) and (E) related to coverage for outpatient prescription drugs. Those provisions were included to implement the Medicare Prescription Drug Improvement and Modernization Act of 2003 but are no longer relevant.

Amendments to subsection (b) require that Medicare supplement applications elicit information as to whether someone younger than 65 qualifies under HB 2516. These changes are necessary to ensure that issuers have the information to comply with the new requirements. The amendments also delete extraneous language from the subsection.

Amendments to Figure: 28 TAC §3.3309(f) remove a reference to enrollment in Part D, which is no longer needed, and remove unnecessary underlines.

An amendment to subsection (g) revises a reference in the rule text that incorrectly refers to parts of Figure: 28 TAC §3.3309(f) as paragraphs of subsection (f).

Amendments also include nonsubstantive rule drafting and formatting changes for plain language and to conform to the agency's current rule drafting style and improve clarity. For example, "shall" is changed to "must" throughout the rule text, and "preexisting conditions" is changed to "preexisting condition limitations."

Section 3.3312. The title of this section is amended to add a reference "Notice Requirements" in light of the notification requirement found in new subsection (f) of this section.

Amendments to subsection (b) delete paragraphs (7) and (9) relating to enrollment in Medicare Part D and the Texas Health Insurance Pool, as the references in these paragraphs are obsolete and unnecessary, and renumber current paragraph (8) as paragraph (7). New subsection (b)(8) identifies for purposes of other amendments individuals meeting the requirements of Insurance Code §1652.059 and enrolled in Medicare before the effective date of the rule amendments.

An amendment in subsection (c)(1) revises a reference to the paragraphs in subsection (b) to reflect the changes to the paragraphs in that subsection. Subparagraphs

(A) and (B) in subsection (c)(1) are amended to implement HB 2516 by clarifying that individuals eligible under that bill are entitled to the same plans that anyone turning 65 is eligible for. To conform to the deletion of subsection (b)(7), subsection (c)(2) is amended to remove provisions related to the removal of prescription drug coverage, and subsection (c)(4) is deleted.

New subsection (c)(4) implements the protections of HB 2516 by providing that individuals eligible under that bill are entitled to the same plans offered to others by the issuer and may not be subject to separate forms or rates.

An amendment deletes current subsection (d)(5) to conform to the deletion of subsection (b)(7). Subsequent paragraphs are renumbered.

An amendment to subsection (d)(6) deletes the reference to the Texas Health Insurance Pool, as it is obsolete. In accordance with Insurance Code §1652.060(d), which authorizes the commissioner to designate enrollment periods by rule, new text is added in subsection (d)(6) to provide a guaranteed issue period for those eligible under HB 2516. As proposed, subsection (d)(6) provided a guaranteed issue period from October 15, 2026, through March 31, 2027, to align with Medicare open enrollment periods and support individuals who may switch from a Medicare Advantage plan to traditional Medicare and want to purchase Medicare supplement coverage. Because the rule amendments are being adopted after October 15, the guaranteed issue period is modified to start December 1, 2026, and run through March 31, 2027.

New subsection (f) requires issuers to provide timely notice to those eligible for the enrollment period created by subsection (d)(6). This will ensure that those eligible under HB 2516 receive notice of their opportunity to realize the benefits of that legislation. As proposed, the text prohibited sending this notice prior to September 1, 2026, or later

than October 15, 2026. Because the rule amendments are being adopted after those dates, the text "not earlier than September 1, 2026, and" has been deleted, and the deadline for sending the notice is modified to be January 1, 2027, to align with the start of the enrollment period.

The amendments include nonsubstantive rule drafting and formatting changes for plain language and to conform the section to the agency's current rule drafting style and improve clarity. For example, "in accordance with" is changed to "according to," and edits are made to paragraph organization for clarity.

Section 3.3324. Amendments to subsection (a) make clarifying changes to implement HB 2516. The changes relate to medical underwriting and exceptions to the required availability of Medicare supplement policies and certificates.

Amendments to subsection (b)(1) are necessary to distinguish between requirements for individuals younger than 65 who are eligible under HB 2516 and those who are not.

Amendments to subsection (b)(2) clarify that an individual turning 65 who previously obtained Medicare supplement coverage due to disability and early enrollment in Medicare has the same rights to obtain Medicare supplement coverage at age 65 as anyone else turning 65. If an individual chooses to remain with their plan, they must be charged the same premium as someone enrolling for the first time at age 65.

New subsection (b)(3) requires notice (beginning 90 days after the effective date of the section) to those enrollees turning 65 of any premium adjustment and new open enrollment period under subsection (b)(2). These changes are consistent with TDI's 2021 Bulletin #B-0027-21 (online at www.tdi.texas.gov/bulletins/2021/B-0027-21.html), which

cited CMS' December 2002 guidance, Transmittal No. 02-03 (available online at www.cms.gov/Medicare/Health-Plans/Medigap/Downloads/mdgp0203.pdf), requiring a second open enrollment opportunity at age 65 for Medicare supplement policyholders who obtained coverage before 65 because of disability.

New subsection (b)(4) implements HB 2516 by requiring that qualifying individuals be charged the same rates as others for some plans and no more than 200% of the rates charged others for other plans. It also prohibits application of preexisting condition exclusions or waiting periods to these qualifying individuals.

New subsection (b)(5) provides that issuers filing for rate increases before January 1, 2028, in which they rely on HB 2516 as justification for the rate increase, must also affirm that the rates for those individuals that do not qualify under HB 2516 will continue to meet the loss ratio standards of 28 TAC §3.3307. This will assist TDI's review of rate increase requests and ensure compliance with rating requirements. In particular, TDI will be reviewing cases in which issuers reexamine their rates and increase them when eligible individuals are moved into the larger risk pool of those who become eligible for Medicare at age 65. In those cases, the rates of those individuals younger than 65 who are not eligible under HB 2516 and who remain in a separate risk pool that now no longer includes individuals with ESRD or ALS should also be reexamined to ensure they are not excessive.

In addition, the amendments include nonsubstantive rule drafting and formatting changes for plain language and to conform the section to the agency's current style and improve clarity.

SUMMARY OF COMMENTS AND AGENCY RESPONSE. TDI provided an opportunity for public comment on the rule proposal for a period that ended on June 17, 2026.

Commenters: TDI received written comments from four commenters: For Members Only Insurance Services and joint comments from the Texas Association of Health Plans (TAHP), America's Health Insurance Plans (AHIP), and the Texas Association of Life and Health Insurers (TALHI). No commenters spoke at a public hearing on the proposal held on June 15, 2026. Commenters in support of the proposal with changes are TAHP, AHIP, and TALHI. Commenters against the proposal are For Members Only Insurance Services.

General Comment.

Comment. One commenter opposes the rule, noting that some insurance companies have paused or discontinued sales of Medicare supplement plans in Texas after HB 2516 went into effect, leading to fewer available plans and causing an increase in rates. The commenter asserts that the rule will reduce access to Medicare supplement plans and cause some seniors to cancel their plans due to cost and enroll in Medicare Advantage plans that may not meet their medical needs.

Agency Response. TDI declines to make a change because the proposed amendments to TDI's Medicare supplement rules are largely required in order to implement HB 2516. The main exercise of discretion in the proposal is to provide a second open enrollment opportunity to the ESRD and ALS populations. However, as discussed in response to the following comment, HB 2516 clearly gave TDI this discretion, which it is exercising due to the lack of evidence that individuals with ESRD and ALS were aware of the limited open enrollment opportunity provided by the bill that has now closed.

Comment on §3.3312(d)(6)

Comment. Three commenters oppose the proposed additional guaranteed issue period for individuals with ESRD and ALS that would run from October 15, 2026, through March 31, 2027. The commenters note that HB 2516 provided a guaranteed issue period from December 1, 2025, to June 1, 2026, a sufficient opportunity to obtain or change coverage. The commenters assert that a guaranteed issue period of 11 and a half months within a span of 16 months is not a limited enrollment window. Finally, the commenters state that the cumulative effect is to compound adverse selection, driving up premiums, while going further than the law requires and further than sound insurance market policy supports.

Agency Response. TDI disagrees and declines to make a change. The commenters do not assert that TDI lacks statutory authority and discretion to create a second open enrollment period. Insurance Code §1652.060, enacted in HB 2516, specifically requires the commissioner to "adopt rules as necessary to administer this section, including rules designating enrollment periods." Though the commenters assert that the ESRD and ALS population has already had a meaningful opportunity to obtain or change coverage, they have presented no evidence that any carrier has done anything to notify their current ESRD/ALS Medicare supplement enrollees of their opportunity to change plans, nor have they presented any evidence of any carrier doing any outreach to those with ESRD and ALS but without Medicare supplement coverage. Given the limited information provided regarding the initial open enrollment period that ended June 1, 2026, TDI believes it would frustrate the intent of the legislation not to provide an additional enrollment opportunity. TDI notes that, in addition to the discretionary rulemaking authority vested in the commissioner as described above, according to the bill analysis for HB 2516, the bill's purpose is to "improve access to Medicare supplement benefit plans for Texans younger

than 65 years of age who qualify for Medicare due to disability, end stage renal disease, or amyotrophic lateral sclerosis by requiring that such individuals be offered coverage under those supplemental plans. . . ." *See* House Research Org., Bill Analysis, Tex. HB 2516, 89th Leg., 2025. Accordingly, TDI has determined it is appropriate to provide a second open enrollment opportunity, aligning with the Medicare general and Medicare Advantage open enrollment periods and require that carriers notify their current impacted enrollees of the limited opportunity to move to another plan. As noted in a preceding paragraph, because the rule amendments are being adopted after October 15, 2026, the guaranteed issue period as proposed is modified to start December 1, 2026, and run through March 31, 2027.

Subchapter T Minimum Standards for Medicare Supplement Policies
28 TAC §§3.3309, 3.3312, and 3.3324

STATUTORY AUTHORITY. TDI adopts amendments to §§3.3309, 3.3312, and 3.3324 under Insurance Code §§1652.005, 1652.051, 1652.060, 1652.101, 1652.103, 1701.060, and 36.001.

Insurance Code §1652.005 requires the commissioner to adopt reasonable rules necessary and proper to carry out Insurance Code Chapter 1652, including rules necessary to retain federal certification as a state with an approved regulatory program.

Insurance Code §1652.051 requires the commissioner to adopt reasonable rules to establish standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons between different Medicare supplement plans. The standards may include provisions relating to initial and subsequent conditions of eligibility. These

rules may also include reasonable rules that specifically prohibit plan provisions that are not otherwise specifically authorized by statute and that the commissioner determines are unjust, unfair, or unfairly discriminatory.

Insurance Code §1652.060 requires the commissioner to adopt rules as necessary to administer that section, including rules designating enrollment periods.

Insurance Code §1652.101 requires the commissioner to adopt reasonable rules to establish minimum loss ratio standards for Medicare supplement plans.

Insurance Code §1652.103 requires the commissioner by rule to provide a process for reviewing and approving or disapproving a proposed premium increase relating to Medicare supplement plans.

Insurance Code §1701.060 gives the commissioner general rulemaking authority to adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including rules that establish procedures and criteria under which forms will be reviewed.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.3309. Requirements for Application Forms and Replacement Coverage.

(a) Application forms must 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 must 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.

(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.

(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 must be elicited from prospective covered persons by asking the following questions: 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 must include questions to elicit information as to whether the applicant qualifies under Insurance Code §1652.059, concerning Coverage for Certain Individuals Younger Than 65, is an eligible person as defined in §3.3312(b) of this title (relating to Guaranteed Issue for Eligible Persons; Notice Requirements), or 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 must list:

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

(2) any other health insurance policies or coverages sold to the applicant in the past five years that 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, must 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, must furnish a notice

regarding replacement of Medicare supplement coverage to the applicant before issuance or delivery of the Medicare supplement policy or certificate. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, must be provided to the applicant, and an additional signed copy must be retained by the issuer. A direct response issuer must 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 must be provided in substantially the following form and must 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, and/or

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

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions waiting periods, elimination periods, or probationary periods. The insurer will reduce any time periods applicable to preexisting 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) The items found in paragraphs (1) and (2) of Figure: 28 TAC §3.3309(f) apply to preexisting condition limitations and 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; Notice Requirements.

(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, who indicate on the application for a Medicare supplement policy that they meet the requirements of this section, and who submit evidence of eligibility as necessary, such as 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 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; must not discriminate in the pricing of a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; and must not impose an exclusion of benefits based on a preexisting condition under 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 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 age 65 or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under §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 provider if the individual were enrolled in a Medicare Advantage plan:

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

(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 §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 §1856), or the plan is terminated for all individuals within a residence area;

(D) the individual demonstrates, according to guidelines established by the Secretary, that:

(i) the organization offering the plan substantially violated a material provision of the organization's contract under 42 U.S.C. 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 covered care according to applicable quality standards; or

(ii) the organization, 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 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 §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 §1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(D) an organization under a Medicare Select policy.

(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, 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 §1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under §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 subsequent enrollment (during which time the individual is permitted to terminate the subsequent enrollment under §1851(e) of the Social Security Act).

(6) The individual, on first becoming enrolled in Medicare Part B, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under §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 loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

(8) The individual meets the criteria in Insurance Code §1652.059, concerning Coverage for Certain Individuals Younger than 65, and enrolled in Medicare Part B before the effective date of this section.

(c) Products that eligible persons are entitled to.

(1) Persons described by subsection (b)(1), (2), (3), (4), and (7) of this section are entitled to a Medicare supplement policy that has a benefit package classified as follows:

(A) Plan A, B, C, F (including F with a High Deductible), K, or L offered by any issuer, for an individual age 65 or older, or an individual who meets the criteria in Insurance Code §1652.059, who first became eligible for Medicare before January 1, 2020, except that for persons under age 65 who do not meet the criteria in Insurance Code §1652.059, it is a policy that has a benefit package classified as Plan A; or

(B) Plan A, B, D, G (including G with a High Deductible), K, or L offered by any issuer, for a 2020 newly eligible individual who is age 65 or older or meets the criteria in Insurance Code §1652.059, except that for persons under age 65 who do not

meet the criteria in Insurance Code §1652.059, it is a policy that has a benefit package classified as Plan A.

(2) Persons described by subsection (b)(5) of this section are entitled to the same Medicare supplement policy in which the individual was most recently enrolled, if available from the same issuer or, if not available, a policy described in paragraph (1) of this subsection.

(3) Persons described by subsection (b)(6) of this section are entitled to any Medicare supplement policy offered by any issuer, with the exception of Plans C or F (including F with a High Deductible) for a 2020 newly eligible individual.

(4) Persons described by subsection (b)(8) of this section are entitled to enroll in any plan type that is offered by any issuer, provided that:

(A) an issuer is not permitted to make Plans C or F (including F with a High Deductible) available to a 2020 newly eligible individual;

(B) coverage must be issued according to terms provided in Insurance Code §1652.060, concerning Enrollment Period for Certain Individuals Younger Than 65; and

(C) notwithstanding §3.3307(d) of this title (relating to Loss Ratio Standards and Refund or Credit of Premiums) and §3.3322(d) of this title (relating to Filing and Approval of Policies, Certificates and Premium Rates; Discontinuance of Forms), an issuer may not have a separate form or rates for persons described by subsection (b)(8) of this section.

(d) Guaranteed issue time period.

(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 the termination or cessation); or

(ii) the date the applicable coverage terminates or ceases; 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 the termination or cessation); or

(ii) the date the applicable coverage terminates or ceases; and

(C) the guaranteed issue period ends 63 days after the date the applicable coverage terminates or ceases.

(2) 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 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 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 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.

(6) In the case of an individual described in subsection (b)(8) of this section, the guaranteed issue period is December 1, 2026, through March 31, 2027.

(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 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 organization or provider, the subsequent enrollment will 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 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 plan or program, the subsequent enrollment will 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 two-year period beginning on the date that the individual first enrolled with the organization, provider, plan, or program.

(f) Notification of enrollment period for certain individuals under age 65. For an insured described by subsection (b)(8) of this section who enrolled in a Medicare supplement policy before the effective date of this section, the issuer must provide notice not later than January 1, 2027, informing the insured of the right to change plans during the enrollment period provided in subsection (d)(6) of this section.

§3.3324. Open Enrollment.

(a) Except as otherwise provided in this section, no issuer may deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, subject an applicant to medical underwriting, nor discriminate in the pricing of 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 before 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 may engage in a premium rating practice that results in higher premiums for any policy solely because the policy is issued under the provisions of this section. An issuer must make available each Medicare supplement policy and certificate to all applicants

who apply for coverage under this section without regard to age, subject to the following exceptions:

(1) an issuer may not make Plans C or F (including F with a High Deductible) available to a 2020 newly eligible individual;

(2) an issuer may not make available a policy or certificate that has been discontinued under §3.3322 of this title (relating to Filing and Approval of Policies, Certificates and Premium Rates; Discontinuance of Forms); and

(3) an issuer may limit availability as permitted in subsection (b) of this section.

(b) The provisions of this subsection apply to Medicare supplement issuers with respect to persons who qualify for Medicare before age 65.

(1) For individuals who do not qualify under Insurance Code §1652.059, concerning Coverage for Certain Individuals Younger Than 65, an issuer must make available, at a minimum, Plan A of the standard Medicare supplement plans to an individual who qualifies under this subsection and may establish a separate form and rating class as permitted under §3.3322 of this title for similarly situated individuals who enroll in Plan A under this section.

(2) When an individual who is enrolled in a plan under this subsection reaches age 65, the individual is entitled to an open enrollment period under subsection (a) of this section as if the individual had enrolled in Medicare Part B on their 65th birthday, and the issuer must begin charging the premium rate that would apply to a new applicant under subsection (a) of this section.

(3) On or after 90 days after the effective date of this section, an issuer covering an individual enrolled in a plan under this subsection must give notice to the

individual not earlier than the individual's 64th birthday and not later than the individual's 65th birthday of the adjustment to the premium and the new open enrollment period required by this section.

(4) The provisions of this paragraph apply to individuals who qualify under Insurance Code §1652.059.

(A) For standardized Medicare supplement Plans A, B, and D, the issuer must charge a qualifying individual the same premium rate that is charged to an individual age 65 for the same plan, at the time of issuance and for the duration that the individual enrolled in the plan is under age 65.

(B) For standardized Medicare supplement plans other than Plans A, B, or D, the issuer must charge a qualifying individual a premium rate that is no higher than 200% of the rate charged to an individual age 65 for the same plan, at the time of issuance and for the duration that the individual enrolled in the plan is under age 65.

(C) Notwithstanding subsections (c) or (d) of this section, an issuer may not apply a preexisting condition exclusion or a waiting period to a qualifying individual.

(5) An issuer filing for a rate increase applicable to a Medicare supplement policy on or before January 1, 2028, in which the rate increase relies on actual or expected experience resulting from the implementation of Insurance Code §1652.059 or §1652.060, concerning Enrollment Period for Certain Individuals Younger Than 65, must include in the filing a statement signed by an actuary as to whether the rates for those insureds under age 65 not qualifying under Insurance Code §1652.059 or §1652.060 satisfy the requirements of §3.3307 of this title (relating to Loss Ratio Standards and Refund or Credit of Premiums).

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

(1) of at least six months, the issuer may not exclude benefits based on a preexisting condition; or

(2) that is less than six months, the issuer must 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 title (relating to Guaranteed Issue for Eligible Persons; Notice Requirements), and §3.3306(b)(1)(A) of this title (relating to Minimum Benefit Standards), subsection (a) of this section may 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-month 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 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), must 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."

CERTIFICATION. The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on November 9, 2026.

Signed by:
Jessica Barta
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Jessica Barta, General Counsel
Texas Department of Insurance

The amendments to 28 TAC §§3.3309, 3.3312, and 3.3324 are adopted.

Signed by:
Amanda Crawford
FE10434BC41A470...

Amanda Crawford
Commissioner of Insurance

Commissioner's Order No. 2026-10219