Regulatory Analysis Form

(Completed by Promulgating Agency)

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INDEPENDENT REGULATORY REVIEW COMMISSION

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IRRC Number: 3189

(1) Agency
Pennsylvania Insurance Department

(2) Agency Number: 11
Identification Number: 256

(3) PA Code Cite: 31 Pa. Code Chapter 89. Subchapter K. §§ 89.772, 89.777b, 89.777c, 89.778, 89.783

(4) Short Title: Medicare Supplement Insurance Minimum Standards

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(6) Type of Rulemaking (check applicable box):

- ☐ Proposed Regulation
- X Final Regulation
- ☐ Final Omitted Regulation
- ☐ Emergency Certification Regulation;
  - ☐ Certification by the Governor
  - ☐ Certification by the Attorney General

(7) Briefly explain the regulation in clear and nontechnical language. (100 words or less)

The Insurance Department amends Title 31, Chapter 89, Subchapter K to meet the new federal mandates for Medicare Supplement Insurance (Medigap) policies as required by the Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, 129 Stat. 87 (MACRA) and as reflected in amendments to the National Association of Insurance Commissioners (NAIC) model regulation adopted by the NAIC on August 29, 2016. The amendments redesignate three types of Medigap plans and discontinue three other types. Beyond these federally-mandated changes, these amendments also create an open enrollment period for Medigap plans any time within the six month period after a retroactive Medicare Part B enrollment.

(8) State the statutory authority for the regulation. Include specific statutory citation.

Generally, sections 206, 506, 1501 and 1502 of the Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412) provide the Insurance Commissioner with the authority and duty to promulgate regulations governing the enforcement of the laws relating to insurance. Sections 5 and 9 of the Medicare Supplement Insurance Act (40 P.S. §§ 3105 and 3109) relate to the specific regulatory authority of the Commissioner over Medigap plans. The Accident and Health Filing Reform Act (40 P.S. § 3801.301 *et seq.*) gives the Department authority to regulate the forms and rates of accident and health insurance products, including Medigap. This statute serves as the specific authority for regulation of open enrollment periods. (40 P.S. § 3801.314). Federal law provides the states with regulatory authority to establish the benefit structures of Medigap plans in accordance with national model laws as discussed below. 42 U.S.C. § 1395ss.

(9) Is the regulation mandated by any federal or state law or court order, or federal regulation? Are there any relevant state or federal court decisions? If yes, cite the specific law, case or regulation as well as, any deadlines for action.

Several of these amendments include changes to Medigap plans and benefits established by federal law. See, the Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, 129 Stat. 87 (MACRA). Specifically, the amendments include changes mandated by MACRA, with respect to benefit structures of certain plans as well as determinations of eligibility. *Id.* codified at 42 U.S.C. § 1395ss(z). In order to continue to regulate the Medigap market, Pennsylvania must adopt the revisions required prior to the sale of approved policies with an effective date of January 1, 2020. 42 U.S.C. § 1395ss(a)(2)(A). The NAIC had urged states to begin the regulatory process prior to December 31, 2017. The changes mandated by federal law will go into effect regardless of Pennsylvania regulatory action, and insurers providing Medigap policies will have to comply with new standardized benefit requirements even if these final-form regulations are not adopted.

(10) State why the regulation is needed. Explain the compelling public interest that justifies the regulation. Describe who will benefit from the regulation. Quantify the benefits as completely as possible and approximate the number of people who will benefit.

The Insurance Department amends 31 Pa. Code, Chapter 89, Subchapter K, to be consistent with the authorizing statute and 42 U.S.C. § 1395ss, as well as 42 CFR § 403.210. Moreover, it is in the public interest that Pennsylvania retain its authority to regulate Medigap plans. Finally, the provision regarding open enrollment, although not specifically mandated by federal law, is nonetheless in the public interest in that it will ensure that certain individuals are not unfairly excluded from Medigap coverage. These final-form regulations would benefit all those who will be enrolled in Medicare and thus eligible for Medigap coverage in 2020. According to the Kaiser Family Foundation, as of 2016, the number of Medicare eligible individuals in Pennsylvania was approximately 2.6 million; as the Commonwealth's population ages, that number will continue to increase.

(11) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulations.

The provisions of this final-form rulemaking relating to standardized policies are no more stringent than federal standards. The creation of an open enrollment period for Medigap policies in the event of a retroactive eligibility determination is not required by federal law, although an open enrollment period for Medicare itself is required by federal law. This provision serves the compelling state interest of ensuring that individuals who were not previously Medicare enrollees, but become enrolled on a retroactive basis, are not locked out of enrollment for supplemental coverage.

(12) How does this regulation compare with those of the other states? How will this affect Pennsylvania's ability to compete with other states?

The standardized policy provisions will likely be adopted by every other state, putting Pennsylvania on a level competitive playing field. California, Illinois, Mississippi, New Jersey, North Carolina, and Oregon currently require an open enrollment period for retroactive eligibility determinations. Adopting this provision will make Pennsylvania more competitive with those states and will protect Pennsylvanians in the same way citizens of those other states are protected.

(13) Will the regulation affect any other regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

This final-form regulation will not affect any other Insurance Department regulations or any regulations of other state agencies.

(14) Describe the communications with and solicitation of input from the public, any advisory council/group, small businesses and groups representing small businesses in the development and drafting of the regulation. List the specific persons and/or groups who were involved. ("Small business" is defined in Section 3 of the Regulatory Review Act, Act 76 of 2012.)

Prior to initiating the formal regulatory process, the Department provided an exposure draft of proposed amendments to representatives of insurance carriers who make up the bulk of the Medigap market in Pennsylvania. These representatives were asked to provide comments within 30 days. No comments were received on the exposure draft.

Highmark, the Insurance Federation of Pennsylvania, Inc. (IFP), and Independence Blue Cross (IBC) submitted comments on the proposed rulemaking during the comment period. United Healthcare (UHC) submitted a comment on April 18, 2018. All comments were taken into consideration. The Department made several editorial changes in responses to public comments received. In response to the comment from the IFP regarding the necessity and statutory authority to promulgate § 89.781(g), the Department is deleting subsection (g) of § 89.781 in this final-form rulemaking. Although the Department believes it possesses the requisite statutory authority to promulgate this provision, the Department also recognizes the need to promulgate the remaining provisions as soon as practicable to ensure stability in the marketplace. The Department intends to revisit adding this provision at a later date in a separate rulemaking.

(15) Identify the types and number of persons, businesses, small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012) and organizations which will be affected by the regulation. How are they affected?

Currently, approximately 2.6 million Pennsylvanians are eligible for Medicare and thus eligible for a Medigap policy. These individuals could be affected by the provisions of this final-form regulation if they attempt to or do enroll in a Medigap policy. According to most recent data, of those 2.6 million eligible people, about 635,000 people are enrolled in Medigap policies and may be impacted by this proposal. Of these, nearly 392,000 are enrolled in plans that would be redesignated by this proposal. Future enrollees in Medicare would be positively affected by this final-form regulation because they would maintain equal access to open enrollment periods in the event of a retroactive eligibility determination and would benefit from the Commonwealth's continued authority to regulate the Medigap market by complying with federal standards.

There are currently approximately 100 companies selling Medigap policies in Pennsylvania that may have to redesignate their plans and create a new open enrollment period under this proposal. Six (6) of these companies qualify as small businesses. The definition of a small business in this context is an insurer who earns less than $38.5 million in direct written premium annually. These companies will be affected in minor ways. Companies will be required to provide an additional open enrollment period in special circumstances, but because they are already accustomed to managing open enrollment periods, this should not require additional investment of time or resources. Finally, compliance with the federal requirement to discontinue and redesignate certain plans will be financially beneficial to companies because they will no longer pay a benefit for first-dollar coverage of Medicare Part B deductible expenses.

(16) List the persons, groups or entities, including small businesses, which will be required to comply with the regulation. Approximate the number that will be required to comply.

All insurance companies selling Medigap policies in Pennsylvania, of which there are approximately 100, would be required to comply with this final-form regulation. As discussed above, six of these are small businesses.

(17) Identify the financial, economic and social impact of the regulation on individuals, small businesses, businesses and labor communities and other public and private organizations. Evaluate the benefits expected as a result of the regulation.

This final-form regulation will benefit individuals enrolled in Medigap policies by ensuring that the Commonwealth's Insurance Department remains the primary regulator of these policies. This benefits individuals by protecting and advancing the specific needs of Pennsylvania insurance consumers and providing services at a closer governmental level to those consumers. These individuals will also benefit from improved access to Medigap policies in the event of a retroactive eligibility determination.

The final-form regulation will benefit businesses by allowing them to continue to do business with the Commonwealth as the primary regulator, rather than requiring coordinated regulatory review between state and federal agencies, thus decreasing the costs of compliance.

(18) Explain how the benefits of the regulation outweigh any cost and adverse effects.

There are minimal anticipated adverse effects. The cost of compliance for businesses will be negligible, as these requirements correspond to already existing requirements. There will be no increased costs for the Department, as these policies and rates are already reviewed by the Department. Therefore, the benefits listed above will greatly outweigh these minimal costs. Medigap enrollees will no longer have the option to purchase a policy that provides first-dollar Medicare Part B deductible coverage, but this is a result of federal, rather than state, changes.

(19) Provide a specific estimate of the costs and/or savings to the **regulated community** associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

This final-form rulemaking does not specifically require insurers to incur any cost related to redesignating its standardized benefit plans or creating an open enrollment period. A new open enrollment period would not result in any direct costs. Redesignation or discontinuance of standardized benefit plans may require communications to enrollees and printing of new literature, but those costs will vary by insurer. Costs, if any, for legal or consulting procedures necessary to ensure compliance with the rulemaking's requirements will also vary based on an insurer's existing processes and procedures.

(20) Provide a specific estimate of the costs and/or savings to the **local governments** associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

This final-form regulation will not impose any costs or result in any savings to local governments.

(21) Provide a specific estimate of the costs and/or savings to the **state government** associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required. Explain how the dollar estimates were derived.

This final-form regulation will not impose any costs or result in any savings to state government.

(22) For each of the groups and entities identified in items (19)-(21) above, submit a statement of legal, accounting or consulting procedures and additional reporting, recordkeeping or other paperwork, including copies of forms or reports, which will be required for implementation of the regulation and an explanation of measures which have been taken to minimize these requirements.

This final-form regulation does not impose any reporting, recordkeeping, or paperwork requirements upon the regulated community.

(22a) Are forms required for implementation of the regulation?

No forms are required for implementation of this regulation.

(22b) If forms are required for implementation of the regulation, **attach copies of the forms here.** If your agency uses electronic forms, provide links to each form or a detailed description of the information required to be reported. **Failure to attach forms, provide links, or provide a detailed description of**

the information to be reported will constitute a faulty delivery of the regulation.

No forms are required for implementation of this regulation.

(23) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:	$	$	$	$	$	$
Regulated Community	$0	$0	$0	$0	$0	$0
Local Government	$0	$0	$0	$0	$0	$0
State Government	$0	$0	$0	$0	$0	$0
Total Savings	$0	$0	$0	$0	$0	$0
COSTS:						
Regulated Community	$0	$0	$0	$0	$0	$0
Local Government	$0	$0	$0	$0	$0	$0
State Government	$0	$0	$0	$0	$0	$0
Total Costs	$0	$0	$0	$0	$0	$0
REVENUE LOSSES:						
Regulated Community	$0	$0	$0	$0	$0	$0
Local Government	$0	$0	$0	$0	$0	$0
State Government	$0	$0	$0	$0	$0	$0
Total Revenue Losses	$0	$0	$0	$0	$0	$0

(23a) Provide the past three year expenditure history for programs affected by the regulation.

Program	FY -3	FY -2	FY -1	Current FY
No programs will be affected by the regulation.	$0	$0	$0	$0

(24) For any regulation that may have an adverse impact on small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012), provide an economic impact statement that includes the following:

(a) An identification and estimate of the number of small businesses subject to the regulation.
(b) The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed regulation, including the type of professional skills necessary for preparation of the report or record.
(c) A statement of probable effect on impacted small businesses.
(d) A description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

The Department reviewed the standard set forth by 13 CFR § 121.201 and the U.S. Small Business Administration (SBA) Table of Small Business Size Standards Matched to North American Industry Classification System (NAICS) Codes to determine the applicability of this regulation to small businesses. Six entities have been identified as affected small businesses based upon these standards. For Direct Health and Medical Insurers, an insurer qualifies as a small business if it has annual receipts (defined as direct written premium) of equal to or less than $38.5 million.

The projected reporting, recordkeeping and other administrative costs associated with this final-form regulation are minimal. No reporting or recordkeeping is required. Administratively, this final-form regulation would require changing internal protocol to allow for an open enrollment period in the event of a retroactive eligibility determination and would also require the discontinuance of some standardized benefit plans and redesignation of others. Because the new benefit plans are standardized and specifically mandated, associated administrative costs of implementation are projected to be very low.

The probable effect on impacted small businesses is expected to be minor. Standardized Medigap benefit plans have changed in the past with little to no disruption to the small business community. Finally, the new open enrollment period may impact small businesses by leading to an increased number of enrollees during time periods other than the annual open enrollment period, but no adverse impact is anticipated as a result thereof.

The Department is unaware of any less intrusive or less costly alternative methods for achieving the purpose of the final-form regulation, which is to continue to standardize Medigap policy offerings in keeping with federal requirements, to provide access to Medigap policies for individuals who have received retroactive eligibility decisions and to promote Medigap coverage for individuals who are eligible by reason of disability rather than age. Furthermore, portions of the final-form regulation are required by federal law, as developed in the NAIC model regulation. Failure to incorporate the required provisions of the NAIC model regulation will result in the Department losing its regulatory authority over Medigap products sold in Pennsylvania.

(25) List any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, the elderly, small businesses, and farmers.

Medicare, and thus Medigap, policies are available to people age 65 and over as well as certain people under age 65 with disabilities. This final-form regulation affects those populations in that it aims to

protect seniors and people with disabilities by continuing to ensure state regulatory oversight of their insurance products and by protecting them from a rating practice that would incorporate the improper consideration of the health status of open enrollees. Finally, this final-form regulation seeks to provide better access to Medigap policies for these populations by mandating a new open enrollment period.

(26) Include a description of any alternative regulatory provisions which have been considered and rejected and a statement that the least burdensome acceptable alternative has been selected.

No other regulatory schemes were considered.

(27) In conducting a regulatory flexibility analysis, explain whether regulatory methods were considered that will minimize any adverse impact on small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012), including:

a) The establishment of less stringent compliance or reporting requirements for small businesses;
b) The establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses;
c) The consolidation or simplification of compliance or reporting requirements for small businesses;
d) The establishment of performance standards for small businesses to replace design or operational standards required in the regulation; and
e) The exemption of small businesses from all or any part of the requirements contained in the regulation.

The Department determined that it was not possible to consider alternative regulatory methods because the final-form regulation is based in large part upon a federally required NAIC model regulation. The Department is not free to change the requirements of the NAIC model regulation to adapt them for small businesses. The portions of the regulation that are not derived from NAIC model regulation do not include particular stringent or complex compliance issues for any regulated entity, regardless of size.

(28) If data is the basis for this regulation, please provide a description of the data, explain in detail how the data was obtained, and how it meets the acceptability standard for empirical, replicable and testable data that is supported by documentation, statistics, reports, studies or research. Please submit data or supporting materials with the regulatory package. If the material exceeds 50 pages, please provide it in a searchable electronic format or provide a list of citations and internet links that, where possible, can be accessed in a searchable format in lieu of the actual material. If other data was considered but not used, please explain why that data was determined not to be acceptable.

No data was used as the basis of this regulation.

(29) Include a schedule for review of the regulation including:

A. The length of the public comment period: 30 days

B. The date or dates on which any public meetings or hearings will be held:	No hearings will be held
C. The expected date of delivery of the final-form regulation:	August, 2018
D. The expected effective date of the final-form regulation:	January, 2019
E. The expected date by which compliance with the final-form regulation will be required:	January, 2019
F. The expected date by which required permits, licenses or other approvals must be obtained:	None are required

(30) Describe the plan developed for evaluating the continuing effectiveness of the regulations after its implementation.

The Department reviews each of its regulations for continued effectiveness on a triennial basis.

Section 9.1 Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After June 1, 2010

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of [-insert proper citation-].

Drafting Note. Each state should insert the proper citation(s) to its statutes or rules that govern Medicare supplement insurance policies and certificates issued prior to the June 1, 2010 effective date of the 2010 Standardized benefit plan standards found in Sections 8.1 and 9.1 of this regulation. It is recommended that each state's applicable statutes or rules for Medicare supplement benefit plans for policies and certificates issued prior to June 1, 2010 be retained and that this section of the Model be adopted in its entirety as a new section to govern policies and certificates issued on and after June 1, 2010. (The benefit plan standards of the Medicare Supplement Model Regulation for policies issued prior to June 1, 2010 are found in Section 9 of this regulation.)

A. (1) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in Section 8.1B of this regulation.

(2) If an issuer makes available any of the additional benefits described in Section 8.1C, or offers standardized benefit Plans K or L (as described in Sections 9.1E(8) and (9) of this regulation), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in subsection A(1) above, a policy form or certificate form containing either standardized benefit Plan C (as described in Section 9.1E(3) of this regulation) or standardized benefit Plan F (as described in 9.1E(5) of this regulation).

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall be offered for sale in this state, except as may be permitted in Section 9.1F and in Section 10 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this Subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8.1B and 8.1C of this regulation; or, in the case of plans K or L, in Sections 9.1E(8) or (9) of this regulation and list the benefits in the order shown. For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. In addition to the benefit plan designations required in Subsection C of this section, an issuer may use other designations to the extent permitted by law.

Drafting Note: It is anticipated that if a state determines that it will authorize the sale of only some of these benefit plans, the letter codes used in this regulation will be preserved. The *Guide to Health Insurance for People with Medicare* published jointly by the NAIC and CMS will contain a chart comparing the possible combinations. In order for consumers to compare specific policy choices, it will be important that a uniform "naming" system be used. Thus, if only Plans A, B, D, F, F with High Deductible, and K (for example) are authorized in a state, these plans must retain their alphabetical designations. An issuer may use, in addition to these alphabetical designations, other designations as provided in Section 9.1D of this regulation.

E. Make-up of 2010 Standardized Benefit Plans:

(1) Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in Section 8.1B of this regulation.

(2) Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Section 8.1C(1) of this regulation.

(3) Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), and (6) of this regulation, respectively.

(4) Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in Section 8.1B of this regulation), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in Sections 8.1C(1), (3), and (6) of this regulation, respectively.

(5) Standardized Medicare supplement [regular] Plan F shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), (5), and (6), respectively.

(6) Standardized Medicare supplement Plan F With High Deductible shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph (b).

(a) The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), (5), and (6) of this regulation, respectively.

(b) The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by [regular] Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

(7) Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (5), and (6), respectively. Effective January 1, 2020, the standardized benefit plans described in Section 9.2 A. (4) of this regulation (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

(8) Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(a) Part A Hospital Coinsurance 61st through 90th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(b) Part A Hospital Coinsurance, 91st through 150th days: Coverage of one hundred percent (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;

(c) Part A Hospitalization After Lifetime Reserve Days are Exhausted: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (j);

(e) Skilled Nursing Facility Care: Coverage for fifty percent (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 Subparagraph (j);

(f) Hospice Care: Coverage for fifty percent (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 Subparagraph (j);

(g) Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph (j);

(h) Part B Cost Sharing: Except for coverage provided in Subparagraph (i), coverage for fifty percent (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 Subparagraph (j);

(i) Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (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 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(9) Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(a) The benefits described in Paragraphs 9.1E(8)(a), (b), (c) and (i);

(b) The benefit described in Paragraphs 9.1E(8)(d), (e), (f), (g) and (h), but substituting seventy-five percent (75%) for fifty percent (50%); and

(c) The benefit described in Paragraph 9.1E(8)(j), but substituting $2000 for $4000.

(10) Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(2), (3) and (6) of this regulation, respectively.

(11) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing

facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3) and (6) of this regulation, respectively, with co-payments in the following amounts:

(a) the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists); and

(b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

Drafting Note: The NAIC expects to periodically review the co-payment levels for Medicare supplement Plan N and make adjustments to this regulation as necessary.

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

Drafting Note: Recognizing the challenge in maintaining standardization while ensuring availability of new or innovative benefits, the drafters have included additional guidance to states in the NAIC Medicare Supplement Insurance Model Regulation Compliance Manual.. This guidance includes a recommendation that states consider making publicly available all approved new or innovative benefits, and requests states to report the approval of all new or innovative benefits to the NAIC Senior Issues Task Force, who will maintain a record of these benefits for use by regulators and others. The Senior Issues Task Force will periodically review state approved benefits and consider whether to recommend that they be made part of standard benefit plan designs in this regulation.

Drafting Note: A state may determine by statute or regulation which of the above benefit plans may be sold in that state. Plan A, which consists of the basic (core) benefits must be made available by all issuers. Therefore, Plan A must be one of the authorized benefit plans adopted by a state. If an issuer offers any benefit plan in addition to Plan A, then the issuer must also offer either Plan C or Plan F. Therefore, if any benefit plan is authorized by a state other than Plan A, then either Plan C or Plan F must be among the authorized benefit plans adopted by a state. Except where a new or innovative benefit is approved by the [commissioner] for sale in a state, a state may not authorize the sale of any Medicare supplement plan other than the standardized Medicare supplement benefit plans (that is, Plans A, B, C, D, F, F With High Deductible, G, K, L, M and N) set forth in this regulation.

Drafting Note: The Omnibus Budget Reconciliation Act of 1990 preempts state mandated benefits in Medicare supplement policies or certificates, except for those states which have been granted a waiver for non-standardized plans.

Section 9.2. Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or After January 1, 2020.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to

individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of [-insert proper state citation-].

A. Benefit Requirements. The standards and requirements of Section 9.1 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

(1) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in Section 9.1 E. (3) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

(2) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in Section 9.1 E. (5) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

(3) Standardized Medicare supplement benefit plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(4) Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in Section 9.1 E. (6) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

Drafting Note: Subsection A.(4), above implements the High Deductible Plan G as a redesignation of the prior High Deductible Plan F because federal law "deems" any reference to Plan F as Plan G for "newly eligible" Medicare beneficiaries. High Deductible Plan G is the same as the High Deductible Plan F except that where the annual out-of-pocket expenses are met with Medicare Part A expenses only, any subsequent Medicare Part B deductible expense incurred by the beneficiary after the required annual out-of-pocket expenses is met may not be paid for by the High Deductible Plan G. Federal law prohibits the sale or issuance of any Medigap policy that provides coverage (i.e. third party payment) of the Part B deductible to a "newly eligible" Medicare beneficiary and was enacted for the purpose of increasing cost-sharing and reducing "first dollar coverage". Treating the Medicare Part B deductible as an out-of-pocket expense of the beneficiary under Plan G High Deductible meets this purpose.

(5) The reference in Plans C or F contained in Section 9.1 A(2) is deemed a reference to Plans D or G for purposed of this section.

B. Applicability to Certain Individuals. This Section 9.2, applies to only individuals that are newly eligible for Medicare on or after January 1, 2020:

(1) by reason of attaining age 65 on or after January 1, 2020; or

(2) by reason of entitlement to benefits under part A pursuant to section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.

C. Guaranteed Issue for Eligible Persons. For purposes of Section 12.E, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) shall be deemed to be a reference

to Medicare supplement policy D or G (including G With High Deductible) respectively that meet the requirements of this Section 9.2A.

D. Applicability to Waivered States. In the case of a State described in Section 1882(p)(6) of the Social Security Act ("waivered" alternative simplification states) MACRA prohibits the coverage of the Medicare Part B deductible for any Medicare supplement policy sold or issued to an individual that is newly eligible for Medicare on or after January 1, 2020.

E. Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in subparagraph A.(4), above may be offered to any individual who was eligible for Medicare prior to January 1, 2020 in to the standardized plans described in section 9.1 E of this regulation.

Drafting Note: The standardized benefit plans described in subparagraphs A.(1) and A.(2), above in this Section are also included as benefit plans D and G in Section 9.1.E (4) and (7).

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FACE SHEET
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(Pursuant to Commonwealth Documents Law)

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Copy below is hereby approved as to form and legality. Attorney General	Copy below is here by certified to be a true and correct copy of a document issued, prescribed or promulgated by:	Copy below is hereby approved as to form and legality. Executive or Independent Agencies
BY: _____ (DEPUTY ATTORNEY GENERAL)	Insurance Department (AGENCY)	BY: Marisa H. J. Lehr
_____ DATE OF APPROVAL	DOCUMENT/FISCAL NOTE NO. 11-256 DATE OF ADOPTION: _____	JUN 11 2018 DATE OF APPROVAL
☐ Check if applicable Copy not approved. Objections attached.	BY: Jessica K. Altman Jessica K. Altman Insurance Commissioner TITLE (EXECUTIVE OFFICER, CHAIRMAN OR SECRETARY)	Deputy General Counsel (~~Chief Counsel, Independent Agency~~) (Strike inapplicable title) ☐ Check if applicable. No Attorney General approval or objection within 30 days after submission.

NOTICE OF FINAL RULEMAKING
INSURANCE DEPARTMENT

31 Pa. Code Chapter 89. Subchapter K.

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

RULES AND REGULATIONS

Title 31—INSURANCE

INSURANCE DEPARTMENT

[31 PA. CODE CH. 89]

Medicare Supplement Insurance Minimum Standards

[__Pa.B. ___]

[_____, _____, 201__]

The Insurance Department (Department) amends Chapter 89, Subchapter K (relating to Medicare Supplement Insurance Minimum Standards) to read as set forth in Annex A. This final-form rulemaking is made under the authority of sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411 and 412), sections 5 and 9 of the Medicare Supplement Insurance Act (40 P.S. § 3105 and § 3109) and section 314 of the Accident and Health Filing Reform Act (40 P.S. § 3801.314).

Purpose

The purpose of this final-form rulemaking is to update the Commonwealth's requirements for Medicare supplement insurance ("Medigap") plans in accordance with changes made to National Association of Insurance Commissioners (NAIC) Model Regulation No. 651. The NAIC model was revised in 2015 in accordance with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub.L. No. 114-10), which mandated certain changes to the benefit structure of the permissible standardized benefit plans for Medigap policies. In addition to updating the Commonwealth's Medigap regulations pertaining to Medigap plans, this rulemaking also establishes an open enrollment period for certain individuals retroactively enrolled in Medicare Part B.

Comments and Responses

Notice of proposed rulemaking was published at 48 Pa.B. 517 (January 20, 2018) with a 30-day public comment period. Highmark, the Insurance Federation of Pennsylvania, Inc. (IFP), and Independence Blue Cross (IBC) submitted comments during the comment period. United Healthcare (UHC) submitted a comment on April 18, 2018. All comments were taken into consideration.

Highmark expressed no objections to the proposed amendments but sought clarification regarding whether section 89.777b(f)(7) allows individuals, who are eligible for Medicare Part B

prior to January 1, 2020, to enroll in newly redesignated high deductible Plan G plans before January 1, 2020. Pursuant to section 89.777c(d), an individual who was eligible before January 1, 2020, may not be enrolled in a plan prior to that date, although these individuals may be made aware of the availability of the new plans.

IBC expressed two concerns in its February 20, 2018 comment. IBC withdrew the first half of its comment, which suggested an editorial change, on May 3, 2018, as it did not relate to the Annex published at 48 Pa.B. 517. With regard to the second portion of IBC comment, the Department notes that it intends to revise the Outlines of Coverage samples on its website after promulgation of this final-form rulemaking.

The IFP expressed support for the amendments, but raised concerns regarding section 89.781(g). Specifically, the IFP questioned the distinction between "ladle rating" and "attained age rating" and challenged the Department's statutory authority to promulgate this provision. The Department believes it has the statutory authority to promulgate the provision prohibiting these practices. However, because it is necessary for the Department to promulgate this regulation as soon as practicable, it is deleting subsection (g) of section 89.781 in this final-form rulemaking. The Department intends to revisit adding this provision at a later date.

UHC's comments were also considered by the Department. First, UHC requested the Department clarify the definition of 2020 Standardized Medicare Supplement Plans to confirm that "issued or delivered" means "issued or delivered for effective dates on or after January 1, 2020." The Department notes that the term "issuance" is synonymous with the term "effective." However, the Department has removed the "or delivered" language in the definition to maintain consistency with the other definitions of plan types found in the existing regulation.

UHC also pointed out two typographical errors in the section 89.777b. The use of the term "ready" instead of "newly" was mistakenly inserted by the Legislative Reference Bureau. The Department has corrected this error in the final-form version. The second typographical error appears to be a formatting construct in the printed version and need not be addressed by the Department. Next, UHC points out a typographical error in section 89.777c(a)(2) and suggests an editorial change to section 89.777c(b)(2)(iv). The Department deleted the redundant "and plan policy" language in section 89.777c(a)(2) and changed "Plan F" to "Plan G" in 89.777c(b)(2)(iv) in the final-form version. Finally, UHC also points out an error in the Federal Register, which need not be addressed by the Department in this rulemaking.

The Independent Regulatory Review Commission (IRRC) submitted two comments: (1) requesting that the Department address Highmark's question with regard to how the enrollment process is envisioned; and (2) requesting the Department meet with insurers to discuss subsection (g) of section 89.781. Both comments have been addressed as explained above.

Affected Parties

This final-form rulemaking applies to insurers licensed to transact accident and health business in this Commonwealth. Specifically, this final-form rulemaking applies to insurers offering Medigap policies.

Fiscal Impact

State government

There will not be a material increase in cost to the Department as a result of this final-form rulemaking.

General public

This final-form rulemaking will not impose costs and will not have a fiscal impact upon the general public.

Political subdivisions

This final-form rulemaking will not impose additional costs on political subdivisions.

Private sector

The insurance industry will likely not incur additional costs associated with complying with this final-form rulemaking.

Paperwork

This final-form rulemaking will not impose additional paperwork on the Department, as no filing is required to be made by insurers. To the extent that insurers would need to update policy forms or enrollee literature, this final-form rulemaking may impose additional paperwork on insurers.

Effective Date and Sunset Date

This final-form rulemaking will become effective upon final-form publication in the *Pennsylvania Bulletin*. Although this final-form rulemaking will be effective upon final-form publication, the benefit standards established by MACRA apply to all policies or certificates issued or delivered on or after January 1, 2020.

Contact Person

Questions or comments regarding this final-form rulemaking may be addressed in writing to Bridget Burke, Regulatory Coordinator, Insurance Department, 1341 Strawberry Square, Harrisburg, PA 17120, fax (717) 772-1969, briburke@pa.gov.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P.S. § 745.5(a)), on January 9, 2018, the Department submitted a copy of the notice of proposed rulemaking, published at 48 Pa.B. 517, to

IRRC and the Chairpersons of the Senate Banking and Insurance Committee and the House Insurance Committee for review and comment.

Under section 5(c) of the Regulatory Review Act, IRRC and the House and Senate Committees were provided copies of comments received, as well as other documents when requested. In preparing the final-form rulemaking, the Department has considered all comments from IRRC and the public.

Under section 5.1(j.2) of the Regulatory Review Act (71 P.S. § 745.5a(j.2)), on _____this final-form rulemaking was deemed approved by the House and Senate Committees. Under section 5.1(e) of the Regulatory Review Act, IRRC met on _____and approved the final-form rulemaking.

Findings

The Commissioner finds that:

(1) Public notice proposed rulemaking was given under sections 201 and 202 of the act of July 31, 1968 (P.L. 769, No. 240) (45 P.S. §§ 1201 and 1202) and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) A public comment period was provided as required by law, and all comments were considered.

(3) These regulations do not enlarge the purpose of the proposed rulemaking published at 48 Pa.B. 517.

(2) These regulations are necessary and appropriate for the administration and enforcement of the authorizing statutes.

Order

The Commissioner, acting under the authorizing statutes, orders that:

(a) The regulations of the Department, 31 Pa. Code Chapter 89, Subchapter K, are amended by amending sections 89.772, 89.777b, 89.778, and 89.783 and adding section 89.777c, to read as set forth in Annex A.

(b) The Department shall submit this order and Annex A to IRRC and the House and Senate Committees as required by law.

(c) The Department shall submit this order and Annex A to the Office of General Counsel and Office of Attorney General for approval as to legality and form, as required by law.

(d) The Department shall certify this order and Annex A, as approved for legality and form, and deposit them with the Legislative Reference Bureau as required by law.

(e) This order shall take effect immediately upon publication of the Pennsylvania Bulletin.

Jessica K. Altman
Insurance Commissioner

Annex A

TITLE 31. INSURANCE

PART IV. LIFE INSURANCE

CHAPTER 89. APPROVAL OF LIFE, ACCIDENT AND HEALTH INSURANCE

Subchapter K. MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

§ 89.772. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

* * * * *

2010 Standardized Medicare supplement benefit plan—A group or individual policy of Medicare supplement insurance issued on or after June 1, 2010.

***2020 Standardized Medicare supplement benefit plan*—A group or individual policy or certificate of Medicare supplement insurance issued ~~or delivered~~ on or after January 1, 2020.**

Applicant—

* * * * *

§ 89.777b. Standard Medicare supplement benefit plans for 2010 Standardized Medicare supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010.

* * * * *

(f) The make up of 2010 Standardized Medicare supplement benefit plans shall be as follows:

* * * * *

(7) Standardized Medicare supplement benefit Plan G shall include only the following: the basic (core) benefit as defined in § 89.776a(2), plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign county as defined in § 89.776a(3)(i), (iii), (v) and (vi). **Effective January 1, 2020, a standardized benefit plan redesignated as high deductible Plan G under § 89.777c(b)(2)(iv) (relating to Standard Medicare supplement benefit plans for 2020 Standardized Medicare supplement benefit plans issued or delivered to individuals ~~ready~~ NEWLY eligible for Medicare on or after January 1, 2020) may be offered to an individual who was eligible for Medicare prior to January 1, 2020.**

(8) Standardized Medicare supplement Plan K shall include only the following:

(i) *Part A hospital coinsurance, day 61 through day 90.* Coverage of 100% of the Part A hospital coinsurance amount for each day used from day 61 through day 90 in any Medicare benefit period.

(ii) *Part A hospital coinsurance, day 91 through day 150.* Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from day 91 through day 150 in any Medicare benefit period.

(iii) *Part A hospitalization after* [*150 days*] ***lifetime reserve days are exhausted***. On 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.

* * * * *

(*Editor's Note*: The following section is proposed to be added and printed in regular type to enhance readability.)

§ 89.777c. Standard Medicare supplement benefit plans for 2020 Standardized Medicare supplement benefit plans issued or delivered to individuals newly eligible for Medicare on or after January 1, 2020.

(a) *Applicability.*

(1) Except as provided in subsection (d), this section applies to a 2020 Standardized Medicare supplement plan issued or delivered to an individual newly eligible for Medicare on or after January 1, 2020, by reason of:

(i) Attainment of 65 years of age on or after January 1, 2020.

(ii) Entitlement to Medicare Part A benefits under section 226(b) or 226A of the Social Security Act (42 U.S.C.A. §§ 426(b) and 426-1) on or after January 1, 2020.

(iii) Entitlement to benefits under section 226(a) of the Social Security Act on or after January 1, 2020.

(2) Benefit plan standards applicable to a Medicare supplement policy ~~and plan policy~~ or certificate issued or delivered to individuals eligible for Medicare before January 1, 2020, remain subject to § 89.777b (relating to Standard Medicare supplement benefit plans for 2010 Standardized Medicare supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010).

(b) *Benefit requirements.* A 2020 Standardized Medicare supplement benefit plan that is advertised, solicited, delivered or issued for delivery in this Commonwealth to an individual newly eligible for Medicare as set forth in subsection (a)(1):

(1) May not provide coverage of the Medicare Part B deductible.

(2) Must meet the standards and requirements of § 89.777b except that:

(i) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and must provide the benefits in § 89.777b(f)(3) but may not provide coverage for any portion of the Medicare Part B deductible.

(ii) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and must provide the benefits in § 89.777b(f)(5) but may not provide coverage for any portion of the Medicare Part B deductible.

(iii) Standardized Medicare supplement benefit Plans C, F and high deductible Plan F may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(iv) Standardized Medicare supplement benefit high deductible Plan F is redesignated as high deductible Plan G and must provide the benefits in § 89.777b(f)(6) but may not provide coverage for any portion of the Medicare Part B deductible. The Medicare Part B deductible paid by a beneficiary enrolled in a Standardized Medicare supplement benefit high deductible ~~Plan F~~ PLAN G plan shall be considered an out-of-pocket expense for purposes of meeting the annual high deductible.

(v) For purposes of this section, the references to Plans C and F in § 89.777b(b)(2) are deemed to be references to Plans D and G, respectively.

(c) *Guaranteed issue for eligible persons.* For purposes of § 89.790(e) (relating to guaranteed issued for eligible persons), in the case of an individual newly eligible for Medicare on or after January 1, 2020, any reference to a standardized Medicare supplement benefit policy classified as Plan C, F or high deductible Plan F is deemed to be a reference to a standardized Medicare supplement benefit Plan D, G or high deductible Plan G, respectively, that meets the requirements of this subsection and subsection (d).

(d) *Offer of redesignated plans to individuals other than those newly eligible.* On or after January 1, 2020, a standardized Medicare supplement benefit plan described in subsection (b)(2)(iv) may be offered to an individual who was eligible for Medicare prior to January 1, 2020, under § 89.777b(f)(7).

§ 89.778. Open enrollment.

(a) ***Prohibitions regarding denial, issuance and pricing of Medicare supplement policies or certificates.***

(1) An issuer may not deny or condition the issuance or effectiveness of a Medicare supplement policy or certificate available for sale in this Commonwealth, 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 in the case of an application for a policy or certificate that is submitted prior to or during the 6-month period beginning with the first day of the first month in which **[an]** **either of the following occurs:**

(i) An individual enrolled for benefits under Medicare Part B.

(ii) An applicant who is retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration received notice of retroactive eligibility to enroll.

(2) Each Medicare supplement policy and certificate currently available from an issuer shall be made available to applicants who qualify under this subsection without regard to age. In the case of group policies, an issuer may condition issuance on whether an applicant is a member or is eligible for membership in the insured group.

(b) ***Exclusion of benefits based on a pre-existing condition prohibited.*** If an applicant qualifies under subsection (a) and submits an application during the time period referenced in subsection (a) and, as of the date of application, has had a continuous period of creditable coverage of at least 6 months, the issuer may not exclude benefits based on a preexisting condition.

(c) ***Reduction of the period of a pre-existing condition exclusion.*** If the applicant qualifies under subsection (a) and submits an application during the time period referenced in subsection (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than 6 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. The HHS Secretary shall specify the manner of the reduction under this subsection.

(d) ***Prevention of the exclusion of benefits under a policy.*** Except as provided in subsections (b) and (c) and §§ 89.789 and 89.790 (relating to prohibition against preexisting conditions, waiting periods, elimination periods and probationary periods in replacement policies or certificates; and **[guarantee]** **guaranteed** issue for eligible persons), subsection (a) will not be construed as preventing the exclusion of benefits under a policy, during the first 6 months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the 6 months before it became effective.

§ 89.781. Filing and approval of policies and certificates and premium rates.

* * * * *

(f) *Combination of forms.*

(1) Except as provided in paragraph (2), 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 § 89.780 (relating to loss ratio standards and refund or credit of premium).

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

~~(g) *Attained age rating.* An issuer may not present for filing or approval a rate structure for a Medicare supplement policy or certificate issued or delivered after _____ (*Editor's Note:* The blank refers to the effective date of adoption of this proposed rulemaking.) based upon a structure or methodology with any grouping of attained ages greater than 1 year. The rate for successive ages may not decrease as age increases.~~

§ 89.783. Required disclosure provisions.

* * * * *

(d) *Outline of coverage requirements for Medicare supplement policies.*

* * * * *

(5) The following items **[shall]** **must** be included in the outline of coverage in the order required in this paragraph:

PREMIUM INFORMATION
(Boldface Type)

We (insert issuer's name) can only raise your premium if we raise the premium for all policies like yours in this Commonwealth. (If the premium is based on the increasing age of the insured, include information specifying when premiums will change.)

[DISCLOSURES
(Boldface Type)

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I and J are no longer available for sale. (This paragraph may not appear after June 1, 2011).]

READ YOUR POLICY VERY CAREFULLY
(Boldface Type)

* * * * *

(6) The cover page and the accompanying charts for Plan A to Plan **[L]** **N** of the Outlines of Coverage are available upon request from the Department in printed and electronic formats. In addition, notice will be published, in the *Pennsylvania Bulletin*, of the availability of the amended outlines when revisions are made available to the Department by the United States Department of Health and Human Services as published in the *Federal Register*. The Outlines of Coverages will be made available on the Department's web site at **[http://www.ins.state.pa.us]**www.insurance.pa.gov.

* * * * *

(f) *Availability of forms.* Applicable forms relating to Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare, Refund Calculations and Reporting of Duplicate Medicare Policies for Medicare Supplement Chapter 89 are available upon request from the Department in printed and electronic formats. In addition, notice will be published, in the *Pennsylvania Bulletin*, of the availability of amended Medicare Supplement forms when revisions are made. These Medicare Supplement forms will be made available on the Department's web site at **[http://www.insurance.state.pa.us]** www.insurance.pa.gov.

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Samuel R. Marshall
President & CEO

February 20, 2018

Jodi Frantz, Deputy Chief Counsel
Bridget Burke, Regulatory Coordinator
Pennsylvania Insurance Department
1341 Strawberry Square
Harrisburg, PA 17120

Re: Medicare Supplement Insurance Minimum Standards – Proposed rulemaking

Dear Ms. Frantz and Burke:

On behalf of our member companies and in coordination with our national counterparts, we offer the following comments on the Insurance Department's proposed amendments to Chapter 89, Subchapter K of its regulations, titled Medicare Supplement Insurance Minimum Standards.

While we endorse most the proposed amendments, we are concerned with the Department's proposed Section 89.781(g), which the Department describes as prohibiting ladle rating as an improper rating practice. That raises two concerns.

1. **The distinction between "ladle rating" and "attained age rating"**

The proposed Section 89.781(g) includes within its prohibition of "ladle rating" the practice of using "attained age rating" of more than one year. Ladle rating alone is prohibited by the second sentence of this subsection: "The rate for successive ages may not decrease as age increases." The Department, however, proposes to also prohibit attained age rating greater than one year through the first sentence of this subsection.

We don't understand why the Department is using this proposed regulation to prohibit both rating practices, even as it only references and objects to ladle rating throughout its regulatory analysis. These are distinct rating practices and should be treated as such, not lumped together or, as here, prohibiting both practices based on the evaluation of only one.

First, the Department justifies it proposed prohibition of ladle rating as a "rating practice that can mislead individuals in the open enrollment market by allowing for the improper consideration of health status." Perhaps, although this seems more a conclusion than a finding based on any analysis. In any event, the Department makes no suggestion that attained age bands suffer the same defect.

Second, the Department itself has acknowledged these are distinct rating practices: **It currently allows attained age rating in Medicare supplement insurance rate filings, as do other states.** So while it may be correct that ladle rating "is not currently used by any insurer in Pennsylvania", the Department ignores the fact that it has been approving the use of attained age rating of more than one year in rate filings from individual insurers without any suggestion that this is an improper or misleading practice.

Should the Department want to change its position on attained age rating, the appropriate forum is the rate review process established in the Accident and Health Filing Reform Act, the same process that has controlled the Department's allowance of this rating practice to date. It should not, however, be allowed to effectively disapprove rate filings and a rating practice it has been approving solely by revising a regulation, certainly absent any new legislative direction.

We therefore recommend Section 89.781(g) be revised to delete its first sentence and any reference to attained age rating and attained age bands. Whether inadvertently or intentionally, this proposed subsection lumps these two distinct rating practices together, even as the supporting regulatory analysis refers only to ladle rating and as the Department's past and current practices show these to be distinct practices. The regulation should be, at a minimum, limited to its professed purpose of prohibiting only ladle rating.

2. The statutory authority for the proposed Section 89.781(g)

The Department cites the Medicare Supplement Insurance Act and the Accident and Health Filing Reform Act as its statutory authority for Section 89.781(g) and its proposed prohibition of ladle rating.

Neither of those acts touches on this rating practice. As the Department acknowledges, federal Medicare law does not prohibit ladle rating, and no other state expressly does so. Nor has the Pennsylvania General Assembly done so, despite an act covering a variety of specifics related to Medicare supplement insurance; and it hasn't delegated that power to the Department.

The Department justifies its proposed prohibition, in part, by saying ladle rating "is an industry practice that is not widely in use and is not currently used by any insurer in Pennsylvania." It doesn't, however, say whether any insurer has sought to use ladle rating in Pennsylvania, now or in the past, and how it handled any such rate filings: Did it disapprove them, on what grounds, and to what result?

This is not to defend ladle rating, as distinct from attained age rating. We believe the Department is correct that no insurer is, or has been, using ladle rating in Pennsylvania, so we have no experience with it.

Still, outlawing ladle rating as "improper" by regulation is a stretch, given the lack of precedent at the federal level, in other states, or even at the NAIC (it is an option in that model regulation that predates the recent changes to the federal Medicare law, none of which touch on this.

And that is especially true given the ambiguity of what constitutes ladle rating – should it be as described in Section 89.781(g), expressly including attained age rating, or as described in the Department's supporting analysis, where the only mention is of ladle rating?

The Department has considerable powers to investigate insurer practices and to prohibit practices it believes are improper. But prohibiting ladle rating by a revision to this regulation, absent any administrative findings or results from other states or jurisdictions, seems beyond the authority given to it in the acts it cites - especially since it includes a reversal of a different rating practice it is currently allowing.

Thank you for the opportunity to comment on this. We again emphasize our support for the bulk of the proposed regulation. We welcome the chance to resolve the concerns with Section 89.781(g) and to get the other revisions enacted as soon as possible.

Sincerely,

Samuel R. Marshall

3189.

Burke, Bridget

From:	Amsden, Nancy B <nancy_amsden@uhc.com>
Sent:	Wednesday, April 18, 2018 1:51 PM
To:	Burke, Bridget
Cc:	Frantz, Jodi (Insurance); Kane, Stephen G
Subject:	MACRA UHC Comments submission
Attachments:	PA MACRA with notes DOI 2.docx

UnitedHealthcare
Medicare Solutions

680 Blair Mill Road
Horsham, PA 19044

April 18, 2018

Bridget Burke, Regulatory Coordinator
Pennsylvania Insurance Department
1341 Strawberry Square
Harrisburg, PA
17120
briburke@pa.gov

cc: Jodi Frantz, Deputy Chief Counsel

Dear Ms. Burke:

UnitedHealthcare Insurance Company is providing a response to the proposed regulation 31 Pa. Code Chapter 89 Subchapter K, 89.772, 89.777b, 89.777c, 89.778, 89.781 and 89.783 - Medicare Supplement Insurance Minimum Standards. We understand that due to the submission date, the Department of Insurance can no longer consider substantive comments, and therefore the comments provided below are only technical in nature.

1. Section 89.772 - comments are as follows:
   (A) The definition for 2020 Standardized Medicare supplement benefit plan reads– *"A group or individual policy or certificate of Medicare supplement insurance issued or delivered on or after January 1, 2020"*, but does not reference "for effective dates" on or after January 1, 2020, as is stated in the model. We would like to suggest, without amending the language of the regulation, that if you interpret "issued or delivered on or after 1/1/2020" to mean issued or delivered for effective dates on or after 1/1/2020, that the Department clarify this in the preamble to the final regulation.

2. Section 89.777b - comments are as follows:

(A) A typographical error was identified in the new language of section (f)(7). The word "*ready*" should be removed and replaced with the word "*newly*".
(B) A typographical error was identified in the third line of section (f)(8)(iii). The word "*appli-cable*" should be revised to read "*applicable*".

3. Section 89.777c - comments are as follows:
   (A) In the first sentence of item (2), the words "*and plan policy*" should be removed so the sentence reads "*...a Medicare supplement policy or certificate issued.....*"
   (B) The reference to "*Plan F*" in the second sentence of subsection (iv) should be replaced by "*Plan G*", since this section describes the plans for people newly eligible for Medicare on or after 1/1/2020. The second sentence should read, "*The Medicare Part B deductible paid by a beneficiary enrolled in a Standardized Medicare supplement benefit high deductible Plan G plan shall be considered an out-of-pocket expense for purposes of meeting the annual high deductible.*"

4. Section 89.783 – states that notice will be published in the Pennsylvania Bulletin regarding the availability of the amended outlines (and cover page) when revisions are made available to the Department by the United States Department of Health and Human Services as published in the Federal Register. We note that the cover page and outlines have been published in the Federal Register at 82 FR 41684 et seq. In passing, we noticed a typo on the cover page shown in the Federal Register. The header for the column for Plans C and F should read "Medicare first eligible before 2020 only" [*Emphasis added*].

We hope our suggestions are helpful. If you have any questions or would like to discuss anything concerning the comments or the proposed regulations, you are welcome to contact me by phone or email.

Sincerely,
Nancy Selig Amsden
Regulatory Affairs Analyst
nancy_amsden@uhc.com
952-406-4386

Attachment: proposed rulemaking with notes

#3189

Burke, Bridget

From:	Levins, Richard F. <Richard.Levins@ibx.com>
Sent:	Thursday, May 3, 2018 2:14 PM
To:	Burke, Bridget
Cc:	Frantz, Jodi (Insurance)
Subject:	RE: Proposed Updates to Medicare Supplement Insurance Regulations

Dear Ms Burke,

This follows my conversation today with Jodi Frantz. As a result of that conversation, I would like to withdraw my first comment below. Thank you for your consideration.

Sincerely,

Richard F. Levins
Vice President, Deputy General Counsel, and
General Counsel - PA Markets
1901 Market Street, 43rd Floor
Philadelphia, PA 19103
P 215 241-3805 | F 215 241-3824
richard.levins@ibx.com

Independence

From: Levins, Richard F.
Sent: Tuesday, February 20, 2018 4:00 PM
To: 'Burke, Bridget' <briburke@pa.gov>
Subject: Proposed Updates to Medicare Supplement Insurance Regulations

Dear Ms Burke,

Below please see our comments to the above referenced proposed regulations.

(1) We reviewed the NAIC Model Regulation versus the Department's Proposed Draft changes for the Medicare Supplement Benefit change Jan.1, 2020.

- On page 2 in the Department's Proposed Draft section, We believe that "(b) *Prohibition of Medicare Part B Deductible plans*" section should actually be placed on page 1 in the "Medicare Part B Deductible" section. The section on page 1 as stated by NAIC deals directly to the Part B Deductible and that wording as designed by the Department on page 2 would fit better to page 1.

While not an issue to the Department's draft information, We read this "No Policy or Certificate can provide a Medicare Part B Deductible" to be ANY such Plan. Whether it is a NAIC Standard Form Plan OR a 65 Special plan it should apply to both.

3189

AGY

Burke, Bridget

From: Levins, Richard F. <Richard.Levins@ibx.com>
Sent: Tuesday, February 20, 2018 4:00 PM
To: Burke, Bridget
Subject: Proposed Updates to Medicare Supplement Insurance Regulations

Dear Ms Burke,

Below please see our comments to the above referenced proposed regulations.

(1) We reviewed the NAIC Model Regulation versus the Department's Proposed Draft changes for the Medicare Supplement Benefit change Jan.1, 2020.

- On page 2 in the Department's Proposed Draft section, We believe that "(b) *Prohibition of Medicare Part B Deductible plans*" section should actually be placed on page 1 in the "Medicare Part B Deductible" section. The section on page 1 as stated by NAIC deals directly to the Part B Deductible and that wording as designed by the Department on page 2 would fit better to page 1.

While not an issue to the Department's draft information, We read this "No Policy or Certificate can provide a Medicare Part B Deductible" to be ANY such Plan. Whether it is a NAIC Standard Form Plan OR a 65 Special plan it should apply to both.

(2) As the Department has their proposed regulation changes, it would be helpful if the Department revises the Outline of Coverage sample for all Carriers to follow for 2020. They did the same for the last changes in 2010 and placed them on their website.

Thank you for the opportunity to submit comments.

Richard F. Levins
Vice President, Deputy General Counsel, and
General Counsel - PA Markets
1901 Market Street, 43rd Floor
Philadelphia, PA 19103
P 215 241-3805 | F 215 241-3824
richard.levins@ibx.com

Independence

Comments of the Independent Regulatory Review Commission

IRRC

Insurance Department Regulation #11-256 (IRRC #3189)

Medicare Supplement Insurance Minimum Standards

March 22, 2018

We submit for your consideration the following comments on the proposed rulemaking published in the January 20, 2018 *Pennsylvania Bulletin*. Our comments are based on criteria in Section 5.2 of the Regulatory Review Act (71 P.S. § 745.5b). Section 5.1(a) of the Regulatory Review Act (71 P.S. § 745.5a(a)) directs the Insurance Department (Department) to respond to all comments received from us or any other source.

1. **Section 89.777b. Standard Medicare supplement benefit plans for 2010 Standardized Medicare supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010. – Clarity; Implementation procedures.**

Relating to Paragraph (f)(7), Highmark requested a clarification of the Department's intent on the enrollment for a person eligible for Medicare Part B in 2019 and whether that person can enroll in the high deductible Plan G in 2019 or must wait until January 1, 2020. We ask the Department to explain in the final-form submittal the enrollment process envisioned and, to the extent necessary, to clarify the language of the regulation.

2. **Section 89.781. Filing and approval of policies and certificates and premium rates. – Consistency with statute; Need; Reasonableness.**

The Preamble states, in part:

> Proposed § 89.781(g) (relating to filing and approval of policies and certificates and premium rates) prohibits the practice referred to as "ladle rating," when, for each year of age attained by an enrollee, the rate decreases until the insured reaches an age at which rates begin to increase significantly each year as age increases.

The response to Regulatory Analysis Form (RAF) question 15 states the Department is not currently aware of any company that practices "ladle rating."

Subsection (g) does not directly use the term "ladle rating." The language added as Subsection (g) addresses "attained age rating" by not allowing "grouping of attained ages greater than 1 year."

The Insurance Federation of Pennsylvania (IFP) agrees that ladle rating is not currently used. However, the wording of Subsection (g) would prohibit not just ladle rating, but also "attained age rating greater than one year," which is used. IFP believes the prohibitions imposed by Subsection (g) are not supported by evidence and would affect rate filings. IFP further questions the Department's citation to its statutory authority to add Subsection (g).

We recommend that the Department meet with affected insurers to discuss whether Subsection (g) is needed and, if so, how to best amend this subsection. In addition, we ask the Department to explain in the final-form regulation submittal its statutory authority to enforce this provision.

Insurance Department

Notice of Final Rulemaking

31 Pa. Code Chapter 89. Subchapter K.

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

Document/Fiscal Note No. 11-256

INSURANCE COMMISSIONER'S CERTIFICATION

I, Jessica K. Altman, hereby certify that I have reviewed this Final Form Regulation and determined that it is consistent with the principles outlined in Executive Order 1996-1.

Jessica K. Altman
Insurance Commissioner

GOVERNOR'S OFFICE OF GENERAL COUNSEL

June 15, 2018

Mr. David Sumner
Executive Director
Independent Regulatory Review Comm.
333 Market Street, 14th Floor
Harrisburg, PA 17101

Re: Insurance Department Final-form Regulation No. 11-256, Medicare Supplement Insurance Minimum Standards

Dear Mr. Sumner:

Pursuant to Section 5a(c) of the Regulatory Review Act, enclosed for your information and review is final-form regulation 31 Pa. Code, Chapter 89. Subchapter K, Medicare Supplement Insurance Minimum Standards.

This rulemaking amends Chapter 89 of Subchapter K of the Department's regulations. The purpose of these amendments is to update Pennsylvania's requirements for Medicare Supplement Insurance (Medigap) plans in accordance to changes made to NAIC Model Regulation No. 651, adopted by the NAIC in 2016. The amendments are necessary for the Pennsylvania Insurance Department to retain its status as the primary regulator of Medicare supplement insurance policies sold in this Commonwealth. In addition to updating Pennsylvania's Medigap regulations to comply with federal requirements, these amendments would also establish an open enrollment period for certain individuals retroactively enrolled in Medicare Part B.

If you have any questions regarding this matter, please contact me at (717) 787-2567.

Sincerely yours,

Bridget E. Burke
Regulatory Coordinator

1341 STRAWBERRY SQUARE | HARRISBURG, PA 17120
Ph: 717-787-2567 | Fx: 717-772-1969 | www.insurance.pa.gov

pennsylvania
INSURANCE DEPARTMENT

TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE REGULATORY REVIEW ACT

I.D. NUMBER:	11-256
SUBJECT:	MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS
AGENCY:	PENNSYLVANIA INSURANCE DEPARTMENT

TYPE OF REGULATION

Proposed Regulation

X Final Regulation

Final Regulation with Notice of Proposed Rulemaking Omitted

120-day Emergency Certification of the Attorney General

120-day Emergency Certification of the Governor

Delivery of Tolled Regulation
a. _____ With Revisions b. _____ Without Revisions

RECEIVED
IRRC
2018 JUN 15 P 2:25

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
		HOUSE COMMITTEE ON INSURANCE:
6-15	Joyce C Peck	**MAJORITY CHAIR – REP. TINA PICKETT**
6-15	Louis Lucas	**MINORITY CHAIR – REP. ANTHONY DELUCA**
		SENATE COMMITTEE ON BANKING & INSURANCE:
6-15	C. Kennedy	**MAJORITY CHAIR: SEN. DONALD C. WHITE**
6-15	A. Ryberg	**MINORITY CHAIR: SEN. SHARIF STREET**
6/15/18	K Cooper	*INDEPENDENT REGULATORY REVIEW COMMISSION*
		ATTORNEY GENERAL (for Final Omitted Only)
		LEGISLATIVE REFERENCE BUREAU (for Proposed Only)

June 15, 2018