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:
Identification Number: 11-256

(3) PA Code Cite: 31 Pa. Code Chapter 89. Subchapter K. §§ 89.772, 89.777b, 89.777c, 89.778, 89.781, 89.783

(4) Short Title: Medicare Supplement Insurance Minimum Standards

(5) Agency Contacts (List Telephone Number and Email Address):

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

- ☒ Proposed Regulation
- ☐ 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 currently seeks to amend 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 would also create an open enrollment period for Medigap plans any time within the six month period after a retroactive Medicare Part B enrollment, and prohibit a practice known as "ladle rating."

(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 rating practices and 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 the proposed 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 has urged states to begin the regulatory process to adopt these revisions 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 proposed 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 seeks to amend 31 Pa. Code, Chapter 89, Subchapter K, to be consistent with the authorizing statute and 42 U.S.C. § 1395ss, as well as 42 C.F.R. 403.210. Moreover, it is in the public interest that Pennsylvania will retain its authority to regulate Medigap plans. Finally, the components of the proposed regulation that are not specifically mandated by federal law are nonetheless in the public interest because they will ensure that certain individuals are not unfairly excluded from Medigap coverage. These proposed 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 with regard 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. Additionally, while ladle rating is not prohibited by federal law, this provision will serve the compelling state interest of prohibiting a rating practice that can mislead individuals in the open enrollment market by allowing for the improper consideration of health status.

(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. Ladle rating is typically not expressly prohibited in other states, but it is an industry practice that is not widely in use and is not currently used by any insurer in Pennsylvania. The purpose of this regulation is to prohibit an improper rating practice. Therefore, this provision will not put Pennsylvania companies at a competitive disadvantage.

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

This proposed 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.)

The Department provided a draft of proposed amendments consistent with the NAIC model to representatives of insurance carriers who make up the bulk of the Medigap market in Pennsylvania, including: Geisinger, Highmark, Capital BlueCross, Humana, and the Insurance Federation of Pennsylvania, which represents Aetna, Colonial Penn, Cigna, Chubb, Continental, Everence, Genworth, Mutual of Omaha, Nationwide, New York Life, Sentinel, State Farm, UnitedHealth, and USAA. These representatives were asked to provide comments within 30 days. No comments were received.

(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 proposed 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 proposed regulation because they would be protected from discrimination based on health status, 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. The Department is not currently aware of any company that practices ladle rating, so its prohibition should not impact any companies. 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 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 proposed 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 and from protection from a rating practice that could result in open enrollment rates that would incorporate the improper consideration of the health status of open enrollees.

The proposed 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 either correspond to already existing requirements or disallow practices that are already not generally used, which may cause some companies to incur at least some administrative expense. 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 proposed regulation does not specifically require insurers to incur any cost related to redesignating its standardized benefit plans, creating an open enrollment period, or avoiding certain rating structures. As discussed above, the proposed prohibition of the ladle rating structure would not impact any insurers currently. 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 proposed 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 proposed 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 proposed 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 proposed 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 C.F.R. § 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 proposed regulation are minimal. No reporting or recordkeeping is required. Administratively, this proposed 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. The Department is unaware of any insurers, including small businesses, utilizing the ladle rating practice that this proposed regulation seeks to prohibit, so that particular provision should result in no impact. Finally, the proposed 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 of that. The Department is unaware of any less intrusive or less costly alternative methods for achieving the purpose of the proposed 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, to promote Medigap coverage for individuals who are eligible by reason of disability rather than age, and to protect Medigap enrollees from a rating practice that could result in provision of open enrollment rates that discriminate based on health status. Furthermore, portions of the proposed 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. Therefore, this proposed regulation affects those populations. This proposed regulation 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 proposed 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 proposed 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:	10/31/18
D. The expected effective date of the final-form regulation:	2/28/19
E. The expected date by which compliance with the final-form regulation will be required:	2/28/19
F. The expected date by which required permits, licenses or other approvals must be obtained:	None will be 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.

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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: _____
DEC 21 2017 DATE OF APPROVAL	DOCUMENT/FISCAL NOTE NO. 11-256	DEC 07 2017 DATE OF APPROVAL
☐ Check if applicable. Copy not approved. Objections attached.	DATE OF ADOPTION _____ BY _____ Jessica K. Altman Acting 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 PROPOSED RULEMAKING
INSURANCE DEPARTMENT

31 Pa. Code Chapter 89. Subchapter K.

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

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 (1) and (7)

PROPOSED RULEMAKING

INSURANCE DEPARTMENT

31 PA. CODE CH. 89
Subchapter K.

Medicare Supplement Insurance Minimum Standards

[__ Pa.B. ____]
[Saturday, _____, 201_]

Preamble

The Insurance Department (Department) proposes to amend Chapter 89, Subchapter K of the Department's regulations (31 Pa. Code §§ 89.751-791) (relating to Medicare supplement insurance minimum standards) to read as set forth in Annex A. The rulemaking is proposed 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

Subchapter K of Chapter 89 sets forth minimum standards for Medicare supplement insurance (Medigap) policies, as well as other requirements that pertain to the sale of Medigap policies, such as limitations on rating practices, requirements to file certain forms, the establishment of open enrollment periods, and standards for marketing. Many of these standards are based in large part on federal requirements. Because Medigap serves as a supplement to Medicare (a program administered exclusively by the federal government), Medigap is also heavily federally regulated. The federal government develops standardized Medigap plans and determines which benefits must be included in each standardized plan type. Only standardized Medigap plans may be sold.

Subchapter K was initially adopted in 1992 and detailed the minimum benefits that needed to be included in each standardized Medigap plan at that time as required by the federal Omnibus Budget Reconciliation Act of 1990. In that statute, the federal government delineated these standards and, instead of promulgating its own federal regulation, charged the National Association of Insurance Commissioners (NAIC) with developing a model regulation to be adopted by the states to implement those requirements. Omnibus Budget Reconciliation Act of 1990, Pub.L. No. 101-508 (1990)(codified as amended at 42 U.S.C. § 1395ss(p)(1992 & Supp. 1998).

States currently enjoy primary regulatory authority over the Medigap industry so long as they adopt regulations that are substantially similar to those established by the NAIC to carry out the intent of Congress. 42 U.S.C. § 1395ss(a)(2)(A). If a state fails to promulgate a regulation that

adopts the changes periodically made by the NAIC to its model regulation in response to new or changed federal requirements, that state will lose its regulatory authority. 42 U.S.C. § 1395ss(b)(2).

In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, 129 Stat. 87 (MACRA), which mandated certain changes to the benefit structure of the permissible standardized benefit plans for Medigap policies. Again, as in 1992, the NAIC developed amendments that reflect those changes and published the August 29, 2016 amendments to NAIC Model Regulation No. 651.

In this case, Pennsylvania has until January 1, 2020 to adopt the changes to the model regulation. The NAIC recommends that, in order to provide adequate time for implementation, states seek to amend their regulations 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 proposed regulations are not adopted.

The purpose of these amendments is to update Pennsylvania's requirements for Medigap plans in accordance with changes made to NAIC Model Regulation No. 651. 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, and disallow certain attained age rating practices.

A copy of the copyrighted NAIC model regulation was provided to the legislative standing committees, the Independent Regulatory Review Commission (IRRC), the Governor's Office of Policy and Planning, the Governor's Office of General Counsel and the Attorney General to assist in their analysis of this proposed rulemaking. Copies of NAIC model regulations are available to the general public by contacting the NAIC.

Explanation of Regulatory Requirements

The following is a description of the changes contained in the proposed rulemaking:

Section 89.772 would define the term "2020 Standardized Medicare supplement benefit plan" to promote readability of proposed section 89.777c and to maintain consistency with previous amendments to the Subchapter.

Section 89.777b would be retained for transitional purposes. Subsection (f)(7) would be amended to allow individuals who were eligible for Medicare Part B prior to January 1, 2020 to enroll in a newly redesignated high deductible Plan G. Subparagraph (f)(8)(iii) would be amended to reflect an editorial change made by the NAIC to the previous model.

Section 89.777c is proposed to be added to specify standards for policies effective on or after January 1, 2020. Specifically, this provision would: prohibit the sale of Medicare Part B deductible plans to individuals who became eligible for Medicare Part B on or after January 1, 2020; re-designate standardized benefit plans C, F and high deductible plan F as standardized

benefit plans D, G and high deductible plan G, respectively; and prohibit the sale of standardized Medigap plans C, F and high deductible plan F to individuals who became eligible for Medicare Part B on or after January 1, 2020.

Section 89.778 is proposed to be amended to reformat subsection (a) and add paragraph (a)(2), which would prohibit an insurer from denying enrollment in a Medigap plan to an individual who is retroactively determined to be eligible for Medicare Part B by the Social Security Administration solely because of the retroactive eligibility determination. This proposed prohibition would extend for the period of time ending six months after the date of the retroactive eligibility determination.

Section 89.781 is proposed to be amended to add subsection (g). This new subsection would prohibit the practice referred to as "ladle rating," where, 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. This prohibition was contemplated in the 2008 version of NAIC Model Regulation No. 651, which encouraged states to assess the necessity of a regulatory intervention with respect to attained age rating.

Section 89.783 is proposed to be amended to remove outdated language pertaining to "disclosures" required by paragraph (d)(5) in accordance with editorial changes made by the NAIC to the 2008 version of NAIC Model Regulation No. 651. Paragraph (d)(6) is proposed to be amended to note the addition of the availability of an Outline of Coverage for Plan N. These proposed amendments would also update the references to the Department's website in paragraph (d)(6) and subsection (f) to reflect the current URL address.

External Comments

The Department circulated pre-exposure drafts of the proposed rulemaking to representatives from the Insurance Federation of Pennsylvania, Pennsylvania Association of Mutual Insurance Companies, Insurance Agents and Brokers, Highmark, Independence Blue Cross and Capital Blue Cross. No comments were received.

Affected Parties

The proposed rulemaking applies to insurers licensed to transact accident and health business in this Commonwealth. Specifically, it applies to those 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 proposed rulemaking.

General public

The proposed amendments would impose no costs and have no fiscal impact upon the general public.

Political subdivisions

The proposed 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 proposed rulemaking.

Paperwork

The proposed rulemaking would 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, the amendments may impose additional paperwork on insurers.

Effectiveness/Sunset Date

The rulemaking will become effective immediately after final adoption and publication in the *Pennsylvania Bulletin* as final-form rulemaking. Although the regulation is effective upon publication, the benefit standards established by MACRA apply to all policies or certificates issued or delivered on or after January 1, 2020. The Department continues to monitor the effectiveness of regulations on a triennial basis; therefore, no sunset date has been assigned.

Contact Person

Questions or comments regarding the proposed rulemaking may be addressed in writing to Bridget Burke, Regulatory Coordinator, Insurance Department, 1341 Strawberry Square, Harrisburg, PA 17120, within 30 days following the publication of this notice in the *Pennsylvania Bulletin*. Questions and comments may also be e-mailed to *briburke@pa.gov* or faxed to (717) 772-1969.

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 this proposed rulemaking and a copy of a Regulatory Analysis Form to IRRC and to the Chairpersons of the House Insurance Committee and the Senate Banking and Insurance Committee. A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, IRRC may convey any comments, recommendations or objections to the proposed rulemaking within 30 days of the close of the

public comment period. The comments, recommendations or objections must specify the regulatory review criteria in section 5.2 of the Regulatory Review Act (71 P.S. § 745.5b) that have not been met. The Regulatory Review Act specifies detailed procedures for review, prior to final delivery of the rulemaking, by the Department, the General Assembly and the Governor of comments, recommendations or objections raised.

Jessica K. Altman
Acting 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

Sec.

89.790. Guaranteed issue for eligible persons.
89.791. Prohibition against use of genetic information and requests for genetic testing.

§ 89.772. Definitions.

* * * * *

***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.**

Bankruptcy—The condition under which a Medicare Advantage organization plan that is not an issuer has filed, or has had filed against it, a petition or other action seeking a declaration of bankruptcy under the provisions of the United States Bankruptcy Code (11 U.S.C.) and has ceased doing business in this Commonwealth.

* * * * *

§ 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) 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:

* * * * *

(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.

* * * * *

§ 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), the requirements of this section apply 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:

A. Attainment of age 65 on or after January 1, 2020.

B. Entitlement to Medicare Part A benefits pursuant to 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.

C. Entitlement to benefits under section 226(a) of the Social Security Act (42 U.S.C.A. § 426(a)) 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 the requirements of § 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 (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) except that:

(i) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained 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 shall provide the benefits contained 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 shall provide the benefits contained 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 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), 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 subparagraph (b)(2)(iv) may be offered to an individual who was eligible for Medicare prior to January 1, 2020 pursuant to § 89.777b(f)(7).**

§ 89.778. Open enrollment.

(a) 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:

(1) an individual enrolled for benefits under Medicare Part B[.]**; or**

(2) 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.

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.

* * * * *

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

* * * * *

(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 {INSERT the effective date of this section} based upon a structure or methodology with any grouping of attained ages greater than one 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 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)

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

* * * * *

(6) The cover page and the accompanying charts for Plan A to [Plan L] **Plan 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**.

* * * * *

Insurance Department

Notice of Proposed 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 Proposed Form Regulation and determined that it is consistent with the principles outlined in Executive Order 1996-1.

Jessica K. Altman
Acting Insurance Commissioner

GOVERNOR'S OFFICE OF GENERAL COUNSEL

January 9, 2018

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

Re: Insurance Department Proposed 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 proposed regulation 31 Pa. Code, Chapter 89. Subchapter K, Medicare Supplement Insurance Minimum Standards.

This proposed 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 and disallow certain attained age rating practices.

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

Sincerely yours,

Bridget E Burke

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

X Proposed Regulation

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 JAN -9 P 3:33

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
		HOUSE COMMITTEE ON INSURANCE:
1-9		**MAJORITY CHAIR – REP. TINA PICKETT**
1-9		**MINORITY CHAIR – REP. ANTHONY DELUCA**
		SENATE COMMITTEE ON BANKING & INSURANCE:
1-9		**MAJORITY CHAIR: SEN. DONALD C. WHITE**
1-9		**MINORITY CHAIR: SEN. SHARIF STREET**
1/9/18	K Cooper	*INDEPENDENT REGULATORY REVIEW COMMISSION*
		ATTORNEY GENERAL (for Final Omitted Only)
1/9/18		***LEGISLATIVE REFERENCE BUREAU (for Proposed Only)***