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GOVERNOR

LESLIE A. NEWMAN
COMMISSIONER

BULLETIN

TO: All Licensed Insurers and Insurance Producers authorized to sell Medicare Supplement Insurance Policies

FROM: Leslie A. Newman, Commissioner *Leslie A Newman*
Department of Commerce and Insurance

RE: Recent Law Changes in Medicare Supplement Insurance Regulation

DATE: December 1, 2010

The purpose of this Bulletin is to give an overview of changes in the law, particularly those relating to the regulation of the sale of Medicare Supplement insurance products ("Medigap") in this state. This Bulletin specifically addresses the expansions of eligibility for the mandated offer of Medigap policies to TennCare Disenrollees by 0780-01-58, the Medicare Supplement Insurance Minimum Standards Regulations; and to persons under age sixty-five (65) eligible for Medicare due to disability or end state renal disease ("ESRD") pursuant to 2010 Tennessee Public Acts, Chapter 978.

Prior to March 3, 2009, companies offering a Medigap product were only required to sell that product to individuals who were eligible for or enrolled in Medicare and who were age sixty-five (65) or older. Eligibility was established either through an open enrollment period of six (6) months triggered by attainment of the qualifying age and Medicare status or through a guaranteed issue period triggered by a qualifying event, usually loss of another type of coverage. On March 3, 2009, Department amendments to the regulations governing Medicare Supplement Insurance, Tenn. Comp. R. & Regs. 0780-01-58, became effective. This amendment established loss of coverage under Title XIX of the Social Security Act, Medicaid ("TennCare") as a qualifying event for guaranteed issue of a policy. After that change, any person who is sixty-five (65) years old or older and becomes disenrolled from TennCare must be given a period of sixty-three (63) days from the date of disenrollment to purchase a Medigap policy. Just like any other population that is eligible for a policy of guaranteed issue, eligible TennCare disenrollees may not be underwritten for purposes of pricing, preexisting condition exclusions, or for a determination of whether to issue coverage. This population must be given unrestricted access to all of the standardized plans to which guaranteed issue eligible persons are entitled under Rule 0780-01-58-.14(5).

Beginning January 1, 2011, as a result of 2010 Tennessee Public Acts, Chapter 978 ("Act"), insurance carriers who offer Medigap plans to individuals age sixty-five (65) and older must also offer those same plans to eligible individuals under the age of sixty-five (65). An individual under age sixty-five (65) must be eligible for Medicare due to a disability or end stage renal disease ("ESRD"), to be eligible for this mandated offering of coverage. Eligible persons will have a six (6) month open enrollment period, beginning with the date of one of the eligibility scenarios outlined in the Act (see below). No one eligible for Medicare as a result of a disability or ESRD may be denied coverage under a Medigap policy because of health status. Eligible individuals under age sixty-five (65) must be offered the same policies with the same standard benefits as the sixty-five (65) and older population, and must be afforded all other protections under the law that are available to the sixty-five (65) and older population, unless specifically excluded in the Act. A copy of the Act is attached.

The following eligibility scenarios trigger a six (6) month open enrollment period under the Act:

- A person who has been enrolled in Medicare Part B since before January 1, 2011 will have six (6) months from that date to purchase a policy;
- A person who becomes enrolled in Medicare Part B after January 1, 2011 will have six (6) months from the date of enrollment to purchase a policy;
- A person who becomes retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration will have six (6) months from the date of the notice of retroactive enrollment to purchase a policy;
- A person who loses access to alternative forms of health insurance coverage such as accident and sickness policies, employer-sponsored group health coverage or Medicare Advantage plans due to termination or cancellation of such coverage because of the individual's employment status, or due to an action by a health insurer or employer that is unrelated to the individual's status, conduct, or failure to pay premiums will have six (6) months from the date of loss of that coverage to purchase a policy; or
- A person who is involuntarily disenrolled from Title XIX (Medicaid) or Title XXI (State Children's Health Insurance Program) of the Social Security Act will have six (6) months from the date of disenrollment to purchase a policy.

Thank you for your attention to this matter. Any questions about the positions set forth in or the intent of this Bulletin should be directed to the Insurance Division, Fourth Floor, Davy Crockett Tower, 500 James Robertson Parkway, Nashville, Tennessee, 37243, and/or telephone number (615) 741-2176.

LAN/lmw

PUBLIC CHAPTER NO. 978

SENATE BILL NO. 3164

By Tracy, Ketron, Black, Yager

Substituted for: House Bill No. 3717

By Carr, McDaniel, Lundberg

AN ACT to amend Tennessee Code Annotated, Title 56, relative to medicare supplement insurance.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-7-1453, is amended by inserting the following as a new subsection (g):

(g)(1) Insurers offering Medicare supplement policies and certificates in this state to persons sixty-five (65) years of age or older shall also offer Medicare supplement policies to persons in this state who are under sixty-five (65) years of age and eligible for and enrolled in Medicare by reason of disability or end stage renal disease. Except as otherwise provided in this section, all benefits, protections, policies, and procedures that apply to persons sixty-five (65) years of age or older shall also apply to persons that are eligible for and enrolled in Medicare by reason of disability or end stage renal disease.

(2) Individuals who are under sixty-five (65) years of age and eligible for Medicare by reason of disability or end stage renal disease may enroll in a Medicare supplement policy at any time authorized or required by the federal government, or within six (6) months after:

(A) Enrolling in Medicare Part B, or by January 1, 2011, whichever is later;

(B) The date of the notice that such person has been retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration;

(C) No longer having access to alternative forms of health insurance coverage such as accident and sickness policies, employer-sponsored group health coverage or Medicare Advantage plans due to termination or cancellation of such coverage because of the individual's employment status, or an action by a health insurer or employer that is unrelated to the individual's status, conduct or failure to pay premiums; or

(D) Being involuntarily disenrolled from Title XIX (Medicaid) or Title XXI (State Children's Health Insurance Program) of the Social Security Act.

(3) Premium rates for Medicare supplement policies and certificates issued pursuant to this subsection (g) may differ between persons who qualify for Medicare who are sixty-five (65) years of age or older and those who qualify for Medicare by reason of disability or end stage renal disease and who are younger than sixty-five (65) years of age; provided, however, that such differences in premium rates are pursuant to rate schedules that are based on sound actuarial principles and are reasonable in relation to the benefits provided.

SECTION 2. Upon the expiration of five (5) years from the enactment of this act, the Department of Commerce and Insurance shall conduct a study for the purpose of determining the appropriateness of separate premium rating for populations under sixty-five (65) years of age and such study, at a minimum, shall evaluate whether continued separate premium rating is justified in comparison to any negative rating impact or increased cost in premium that would occur to the Medicare supplement insurance population taken as a whole if such separate premium rating were not allowed. The cost of any such study shall be borne by the department within the existing resources of the department at the time of the study.

SECTION 3. For purposes of promulgating rules and regulations, this act shall take effect upon becoming a law, for all other purposes, this act shall take effect on January 1, 2011, the public welfare requiring it.

PASSED: May 13, 2010



RON RAMSEY
SPEAKER OF THE SENATE



KENT WILLIAMS, SPEAKER
HOUSE OF REPRESENTATIVES

APPROVED this 27th day of May 2010

A handwritten signature in black ink, appearing to read "Phil Bredeesen", written over a horizontal line.

PHIL BREDESEN, GOVERNOR