DEPARTMENT OF INSURANCE
18 DE Admin. Code 1501
Statutory Authority: 18 Delaware Code, Section 1501 (18 Del.C. §1501)

ORDER

1501 Medicare Supplement Insurance Minimum Standards

FINAL

A public hearing was held on August 3, 2004 to receive comments on an amendment to Section 12 of Regulation 1501 relating to Medicare Supplement Insurance Minimum Standards. By my order of June 21, Deputy Insurance Commissioner F.L. Peter Stone was appointed hearing officer to receive comments and testimony on the proposed regulation. Public notice of the hearings and publication of proposed Regulation 1501 in the Register of Regulations and two newspapers of general circulation was in conformity with Delaware law. Two persons attended the public hearing, a representative of the Delaware Department of Insurance and a representative of BCBSD, Inc. Written comments in support of the proposed change were received from Delaware Developmental Disabilities Council, the State Counsel for Persons with Disabilities and the Governor's Advisory Council for Exceptional Citizens and AmeriHealth. A submission was also received from a trade group, America's Health Insurance Plans ("AHIP").

Summary Of The Evidence And The Information Submitted

I have reviewed the FINAL REPORT AND RECOMMENDATION OF THE HEARING OFFICER dated August 9, 2004. The written comments received supported the proposed change because it expanded the group of persons who would be eligible for guaranteed issue of health insurance that is primary to Medicare as well as the already existing guarantee for persons whose insurance is supplemental to Medicare. The BCBSD representative requested clarification of the term "some or all" in the proposed language. The Department responded that the language tracked the same provisions in other state's corresponding regulations. The Department also noted that the purpose was to reinstate the language that had been deleted when the regulation was last amended in 2002. AHIP's comments were mostly neutral and raised the question of cost for consumers as a result of the broader base of persons entitled to guaranteed issue insurance.

Findings Of Fact

Upon review of the regulation as it existed prior to the 2002 amendment, I find that the proposed language is identical to the phrase that had been deleted in the prior amendment. This change would, in effect, bring Delaware back to where it was for ten years prior to the 2002 amendment. I also find that the proposed amendment does not conflict with the federal laws that apply to the State's ability to enforce this regulation with this amendment. In fact, most states, especially those in the Northeast Region of the National Association of Insurance Commissioners have this clause in their existing regulations. While AHIP raised the issue of cost, it also acknowledged that it is likely that there will be relatively few individuals seeking the benefits provided by the new re-installed language. I note that there was no opposition to the proposed change to the regulation.

Decision

Based on the provisions of 18 **Del.C**. §§311 and 3403, and the record in this docket, I adopt the FINAL REPORT AND RECOMMENDATION OF THE HEARING OFFICER dated August 9, 2004 and order that Regulation 1501 Section 12.2.1 be amended as provided for in the notice published in the Delaware Register of Regulations 8 DE Reg. 62 (7/1/04) as follows:

12.2.1 The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual~~.~~; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual because the individual leaves the plan.

I further order that the proposed change shall become effective on September 15, 2004.

Donna Lee H. Williams
Insurance Commissioner

12.0 Guaranteed Issue for Eligible Persons

12.1 Guaranteed Issue

12.1.1 Eligible persons are those individuals described in section 12.2, who seek to enroll under the policy during the period specified in section 12.3, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

12.1.2 With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in section 12.5 that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

12.2 An eligible person is an individual described in any of the following paragraphs:

12.2.1 The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual because the individual leaves the plan.

12.2.2 The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare+Choice plan:

12.2.2.1 The certification of the organization or plan under this part has been terminated; or

12.2.2.2 The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

12.2.2.3 The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

12.2.2.4 The individual demonstrates, in accordance with guidelines established by the Secretary, that

12.2.2.4.1 The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

12.2.2.4.2 The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

12.2.2.5 The individual meets such other exceptional conditions as the Secretary may provide.

12.2.3 The individual is enrolled with:

12.2.3.1 An eligible organization under a contract under section 1876 of the Social Security Act (Medicare Cost);

12.2.3.2 A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

12.2.3.3 An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

12.2.3.4 An organization under a Medicare Select policy; and

12.2.3.5 The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under section 12.2.2.

12.2.4 The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

12.2.4.1 Of the insolvency of the issuer or bankruptcy of the non-issuer organization or of other involuntary termination of coverage or enrollment under the policy;

12.2.4.2 The issuer of the policy substantially violated a material provision of the policy; or

12.2.4.3 The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

12.2.5 Subsequent first time enrollment with Medicare+Choice

12.2.5.1 The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and

12.2.5.2 The subsequent enrollment under subparagraph (a) is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

12.2.6 The individual, upon first becoming eligible for benefits under Part A of Medicare at age 65, enrolls in a Medicare+Choice plan under Part C of Medicare, or with a PACE provider under section 1894 of the social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

12.3 Guaranteed Issue Time Periods

12.3.1 In case of an individual described in section 12.2.1, the guaranteed issue period begins on the later of:

12.3.1.1 the date the individual receives a notice of termination or cessation of all supplemental health benefits (or if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or

12.3.1.2 the date that the applicable coverage terminates or ceases and ends sixty-three (63) days thereafter;

12.3.2 In the case of an individual described in sections 12.2.2, 3, 5 or 6 whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

12.3.3 In the case of an individual described in section 12.2.4.1, the guaranteed issue period begins on the earlier of:

12.3.3.1 the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and

12.3.3.2 the date that the applicable coverage is terminated and ends on the date that is sixty-three (63) days after the date the coverage is terminated;

12.3.4 In the case of an individual described in sections 12.2.2, 4.2, 4.3, 5 or 6 who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date: and

12.3.5 In the case of an individual described in 12.2 but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

12.4 Extended Medigap Access for Interrupted Trial Periods

12.4.1 In the case of an individual described in 12.2.5. (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in 12.2.5.1 is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in section 12.2.5.

12.4.2 In the case of an individual described in section 12.2.6 (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in section 12.2.6 is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in section 12.2.6; and

12.4.3 For purposes of sections 12.2.5 and 6, no enrollment of an individual with an organization or provider described in section 12.2.5.1, or with a plan or in a program described in section 12.2.6, may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

12.5 Products to Which Eligible Persons are Entitled

The Medicare supplement policy to which eligible persons are entitled under:

12.5.1 Section 12.2.1, 2, 3, and 4 is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F offered by any issuer.

12.5.2 Section 12.2.5 is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in section 12.5.1.

12.5.3 Section 12.2.6 shall include any Medicare supplement policy offered by any issuer.

12.6 Notification Provisions

12.6.1 At the time of an event described in section 12.2 because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under section 12.1. Such notice shall be communicated contemporaneously with the notification of termination.

12.6.2 At the time of an event described in section 12.2 because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under section 12.1. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

7 DE Reg. 800 (12/1/02)

*** PLEASE NOTE: AS THE REST OF THE REGULATION WAS NOT AFFECTED, IT IS NOT BEING REPRODUCED HERE.**

8 DE Reg. 465 (9/01/04)