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CHAPTER 836
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

FILING CAPTION: Medicare Supplement Insurance proposed rule amendments

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RULES:
836-052-0138, 836-052-0142, 836-052-0143, 836-052-0156

AMEND: 836-052-0138

NOTICE FILED DATE: 10/26/2022

RULE SUMMARY: Rule allows guaranteed issue of Medicare Supplement policies to individuals who qualify for Medicare by reason of disability and move to Oregon from a state that does not permit Medicare Supplement policies to be issued to persons under age 65.

CHANGES TO RULE:

836-052-0138
Open Enrollment ¶

(1)(a) An issuer may not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, 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 Medicare supplement policy or certificate that is submitted to the issuer prior to or during the six month period beginning with the first day of the first month in which an individual is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available on a guaranteed issue basis to all applicants who qualify under this section without regard to age.¶
(b) If a person under the age of 65 applies for enrollment under Medicare Part B due to disability and is initially denied as ineligible, but upon conclusion of the person's appeals process the person is awarded retroactive enrollment, the six month period described in this section begins on the first day of the first month after the person receives written notice of retroactive enrollment.¶
(2)(a) If an applicant qualifies under section (1) of this rule and submits an application during the time period referenced in section (1) of this rule and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition;¶
(b) If the applicant qualifies under section (1) of this rule and submits an application during the time period referenced in section (1) of this rule and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The

manner of the reduction under this subsection shall be the manner prescribed in 42 USC 300gg(a)(3) as of the effective date of this rule.¶
(3) Except as provided in section 2 of this rule and OAR 836-052-0142 and 836-052-0190, section (1) of this rule shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.¶
(4) This section applies to a person who qualifies for Medicare by reason of disability and who obtains a Medicare supplement policy during the six month period described in section (1) of this rule. For the period that a person to whom this section applies is 65 years of age or less, the premium charged the person by the issuer shall not be greater than the premium charged by the issuer for persons who are 65 years of age. Following that period, for issuers who charge rates on policies on the basis of attained age, the rating plan shall not differentiate on the basis of the reason for eligibility for Medicare Part B.¶
(5) An issuer must comply with section (1) of this rule with respect to a person:¶
(a) Who qualifies for Medicare by reason of disability, who first enrolls for benefits under Medicare Part B on or after September 1, 1993, and who applies for a Medicare supplement policy or certificate during the period of eligibility described in section (1) of this rule; ~~or~~¶
(b) Who enrolled in Medicare Part B before attaining 65 years of age, who applies for a Medicare supplement policy or certificate upon attaining 65 years of age, during the period of eligibility described in section (1) of this rule that would apply if the person first enrolled in Medicare Part B upon attaining 65 years of age; or¶
(c) Who qualifies for Medicare by reason of disability and has moved to Oregon from a state that does not require Medicare Supplement policies to be issued to persons under age 65. The guaranteed issue period begins on the date that the individual establishes residency in Oregon and ends 63 days thereafter.
Statutory/Other Authority: ORS 743.683
Statutes/Other Implemented: ORS 743.~~010~~,683, ORS 743.~~683~~010

AMEND: 836-052-0142

NOTICE FILED DATE: 10/26/2022

RULE SUMMARY: Rule adds guaranteed issue for individuals who lose Tricare that supplements Medicare to the current rule and removes outdated “conversion” and “portability” plans from the types of plans that supplement Medicare.

CHANGES TO RULE:

836-052-0142
Guaranteed Issue for Eligible Persons ¶

(1) Guaranteed issue:¶
(a) Eligible persons are those individuals described in section (2) of this rule who seek to enroll under the policy during the period specified in section (3) of this rule and who submit evidence of the date of termination, disenrollment or Medicare Part D enrollment with the application for a Medicare supplement policy.¶
(b) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in section (5) of this rule 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.¶
(2) Eligible persons. An eligible person is an individual described in any of the following paragraphs:¶
(a) The individual is enrolled under an employee welfare benefit plan, an individual~~, conversion or portability~~ health benefit plan,~~ or~~ a state Medicaid plan as described in Title XIX of the Social Security Act or Tricare as described in Title XVIII of the Social Security Act 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 all health benefits to the individual.¶
(b) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older 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 in this subsection that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare Advantage plan:¶
(A) The certification of the organization or plan has been terminated;¶
(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;¶
(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in 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;¶
(D) The individual demonstrates, in accordance with guidelines established by the Secretary, that:¶
(i) 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¶
(ii) 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¶
(E) The individual meets such other exceptional conditions as the Secretary may provide.¶
(c)(A) The individual is enrolled with:¶
(i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);¶
(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;¶
(iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or¶
(iv) An organization under a Medicare Select policy; and¶
(B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under section (2)(b) of this rule.¶

(d) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:¶
(A)(i) Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or¶
(ii) Of other involuntary termination of coverage or enrollment under the policy.¶
(B) The issuer of the policy substantially violated a material provision of the policy; or¶
(C) The issuer, 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.¶
(e)(A) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under 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¶
(B) The subsequent enrollment under paragraph (A) of this subsection is terminated by the enrollee during any period within the first 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¶
(f) The individual, ~~upon first~~within six months after becoming enrolled ~~for benefits under~~in Part B of Medicare ~~part A~~, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and dis-enrolls from the plan or program by not later than 12 months after the effective date of enrollment.¶
(g) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in section (5)(d) of this rule.¶
(3) Guaranteed Issue Time Periods.¶
(a) In the case of an individual described in section (2)(a) of this rule, the guaranteed issue period begins on the later of:¶
(A) 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 a termination or cessation); or¶
(B) The date that the applicable coverage terminates or ceases; and ends 63 days thereafter.¶
(b) In the case of an individual described in section (2)(b), (c), (e) or (f) of this rule whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated;¶
(c) In the case of an individual described in section (2)(d)(A), the guaranteed issue period begins on the earlier of:¶
(A) 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¶
(B) The date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.¶
(d) In the case of an individual described in section (2)(b), (d)(B), (d)(C), (e) or (f) of this rule, who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date; and¶
(e) In the case of an individual described in section (2)(g) of this rule, the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D; and¶
(f) In the case of an individual described in section (2) of this rule 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 63 days after the effective date.¶
(4) Extended Medigap access for interrupted trial periods.¶
(a) In the case of an individual described in section (2)(e) of this rule (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in section (2)(e)(A) is involuntarily terminated within the first 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 (2)(e) of this rule.¶
(b) In the case of an individual described in section (2)(f) of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in section (2)(f) of this rule is involuntarily terminated within the first 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 (2)(f) of this rule; and¶
(c) For purposes of sections (2)(e) and (f) of this rule, no enrollment of an individual with an organization or provider described in section (2)(e)(A) of this rule, or with a plan or in a program described in section (2)(f) of this

rule, 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.¶
(5) Products to which eligible persons are entitled. The Medicare supplement policy to which eligible persons are entitled under:¶
(a) Section (2)(a), (b), (c) (except for coverage described in subparagraph (c)(A)(iv)) and (d) of this rule is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, D, F (including F with a high deductible), G, K, L, M or N offered by any issuer;¶
(b) Section (2)(c)(A)(iv) and (f) of this rule is any Medicare supplement policy described in OAR 836-052-0132 offered by any issuer;¶
(c)(A) Subject to paragraph (B) of this subsection, section (2)(e) of this rule 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 subsection (a) of this section.¶
(B) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this paragraph is:¶
(i) The policy available from the same issuer but modified to remove prescription drug coverage; or¶
(ii) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer.¶
(d) Section (2)(g) of this rule is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, D, F (including F with a high deductible), G, K, or L, M & N and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.¶
(6) Notification provisions:¶
(a) At the time of an event described in section (2) of this rule 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 the individual's rights under this rule, and of the obligations of issuers of Medicare supplement policies under section (1) of this rule. Such notice shall be communicated contemporaneously with the notification of termination.¶
(b) At the time of an event described in section (2) of this rule 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 the individual's rights under this rule, and of the obligations of issuers of Medicare supplement policies under section (1) of this rule. Such notice shall be communicated within ten working days of the issuer's receiving notification of disenrollment.
Statutory/Other Authority: ORS 743.684
Statutes/Other Implemented: ORS 743.~~010~~,684, ORS 743.~~684~~010

AMEND: 836-052-0143

NOTICE FILED DATE: 10/26/2022

RULE SUMMARY: Rule extends the guaranteed issue window for the birthday rule to include the period 30 days prior to the person's birthdate.

CHANGES TO RULE:

836-052-0143
Annual Opportunity to Select Another Medicare Supplement Policy or Certificate ¶

(1) For the purposes of this rule, for 1990, 2010, and 2020 Medicare Supplement Plans, "same or lesser benefits" means a policy or certificate of the same or lower benefit level as indicated on a chart available on the website of the Division of Financial Regulation of the Department of Consumer and Business Services.¶
(2) Beginning 30 days prior to~~n~~ a person's birthday and for 30 days after the person's birthday, a person enrolled in a Medicare supplement policy may cancel the person's existing Medicare supplement policy or certificate and purchase or select another Medicare supplement policy or certificate with the same or lesser benefits to replace the existing Medicare supplement policy or certificate. An issuer may not deny or condition the issuance or effectiveness, nor discriminate in the pricing of the replacement policy or certificate on the basis of health status, claims experience, receipt of health care or medical condition of the applicant.¶
(3) This rule does not apply to Medicare supplement policies or certificates issued or delivered before January 1, 1990.
Statutory/Other Authority: ~~ORS 731.244,~~ ORS 743.010, ORS 743.680 - 743.689, 731.244
Statutes/Other Implemented: ORS 743.010, ORS 743.683~~;~~ - 743.684

AMEND: 836-052-0156

NOTICE FILED DATE: 10/26/2022

RULE SUMMARY: Requires commissions or other compensation to an insurance producer or other representative for the sale or renewal of a guaranteed issue Medicare supplement policy or certificate to be made on the same basis as for any other Medicare supplement policy or certificate.

CHANGES TO RULE:

836-052-0156
Permitted Compensation Arrangements ¶

(1) An issuer or other entity may provide commission or other compensation to an insurance producer or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation, including overrides and other sales-connected remuneration to field supervisory personnel, does not exceed 200 percent of the commission or the compensation paid for selling or servicing the policy or certificate in the second year or period.¶
(2) The commission or other compensation to an insurance producer or other representative for the sale or renewal of a guaranteed issue Medicare supplement policy or certificate must be made on the same basis as for any other Medicare supplement policy or certificate. ¶
(3) The commission or other compensation provided in subsequent renewal years must be the same as that provided in the second year or period and must be provided for a reasonable number of renewal years. The total number of renewal years shall not be fewer than five renewal years.¶
(~~3~~4) An issuer or entity shall not provide compensation to its insurance producers and an insurance producer shall not receive compensation greater than the renewal compensation payable by the replacing issuer if an existing policy or certificate is replaced.¶
(4~~5~~) For purposes of this rule, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including but not limited to bonuses, gifts, prizes, awards and finder's fees.¶
(~~5~~6) Violation of this rule is an unfair trade practice under ORS 746.240.
Statutory/Other Authority: ORS ~~731.244,~~ 743.010, 743.013, 743.680 - 743.689, 746.240, 731.244
Statutes/Other Implemented: ORS 743.684(3)