SUBCHAPTER T. MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT POLICIES 28 TAC §3.3307

INTRODUCTION. The Texas Department of Insurance (TDI) proposes to amend 28 TAC §3.3307, concerning loss ratio standards and refund or credit of premiums.

EXPLANATION. The current Medicare Supplement Data Call rule in 28 TAC §3.3307(f) requires Medicare supplement individual or group policy issuers to annually submit to TDI their refund or credit calculations on Medicare supplement insurance policies, to document the calculations they must make each year in determining any need to refund premiums to policyholders. TDI's Actuarial Data Team currently collects this calculation data; however, there is no further requirement on the team to subsequently use it. This results in a depletion of TDI manpower and resources to create a large repository of frequently unused data.

Amendments to §3.3307 would change the requirement to provide the data to TDI, to simply provide that issuers keep the data and make it available to TDI upon request. This change will ease this potentially costly burden on issuers, as they would no longer be required to annually file their calculations with TDI, while maintaining TDI's access to that data when needed. Insurers would keep the calculations on file and make them available should the Commissioner need that information to review trends in loss ratio standards and refund or credit of premiums in the interest of consumer protection and market fairness.

The amendments to §3.3307(f) remove the reporting requirement to submit an issuer's refund or credit calculation to TDI by May 31 each year. The amendments replace this with a requirement that issuers retain documentation supporting their refund or credit calculations for five years and that they provide the information to TDI upon request and in the manner prescribed by the Commissioner. An amendment is also proposed for

Figure: 28 TAC §3.3307(f), to remove the final page of the Medicare Supplement Refund Calculation Form. This page is used only for reporting data under the section, and it is no longer necessary because issuers will no longer be required to report that data to TDI.

In addition to the previously described amendments, for consistency with current agency style, TDI proposes to change the word "percent" to the percent symbol in §3.3307(a)(1) and (2); (c)(1) and (2); and (d)(1)(F), (3), and (4)(B) and (C).

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Barbara Snyder, chief actuary of the Life and Health Division, has determined that during each year of the first five years the proposed amendments are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the sections, other than that imposed by the statute. Ms. Snyder made this determination because the proposed amendments do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed amendments.

Ms. Snyder does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Ms. Snyder expects that administering the proposed amendments will have the public benefit of conserving agency resources and alleviating the regulatory burden on companies of aggregating and submitting data to TDI.

Ms. Snyder expects that the proposed amendments will impose a cost on stakeholders to implement the retention responsibility for this data. The cost could involve some small data storage expenses associated with the proposed record retention requirement. However, those costs are expected to be minimal and, overall, they will be offset by companies' savings from no longer being required to annually aggregate and send TDI data.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed amendments will not have an adverse economic effect on small or micro businesses, or on rural communities, because the amendments result in a net savings for stakeholders. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal results in a net savings for regulated persons. No additional rule amendments are required under Government Code §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed amendments are in effect, the proposed rule:

- will not create or eliminate a government program;
- will not require the creation of new employee positions or the elimination of existing employee positions;
- will not require an increase or decrease in future legislative appropriations to the agency;
- will not require an increase or decrease in fees paid to the agency;
- will not create a new regulation;
- will expand, limit, or repeal an existing regulation;
- will not increase or decrease the number of individuals subject to the rule's applicability; and
- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TDI has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on May 24, 2021. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

To request a public hearing on the proposal, submit a request before the end of the comment period to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030. The request for public hearing must be separate from any comments and received by TDI no later than 5:00 p.m., central time, on May 24, 2021. If TDI holds a public hearing, TDI will consider comments presented at the hearing.

SUBCHAPTER T. MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT POLICIES

28 TAC §3.3307.

STATUTORY AUTHORITY. TDI proposes §3.3307 under Insurance Code §1652.103 and §36.001.

Insurance Code §1652.103 provides that the Commissioner may adopt rules that provide for a process for reviewing and approving or disapproving a proposed premium increase relating to a Medicaid Supplement Benefit Plan.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. Section 3.3307 implements Insurance Code Chapter 1652, which requires the Commissioner to establish minimum loss ratio standards for Medicare supplement benefit plans.

TEXT.

§3.3307. Loss Ratio Standards and Refund or Credit of Premiums.

(a) Minimum aggregate loss ratio standard. A Medicare supplement individual or group policy form may not be delivered or issued for delivery unless the individual or group policy form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregated benefits (not including anticipated refunds or credits) provided under the individual policy form or group policy form, on the basis of incurred claims experience or incurred health care expenses where coverage is provided by an HMO on a service, rather than reimbursement, basis and earned premiums for the applicable period, not including any changes in additional reserves and in accordance with generally accepted actuarial principles and practices:

(1) at least 75% [~~percent~~] of the aggregate amount of premiums earned in the case of group policies; or

(2) at least 65% [~~percent~~] of the aggregate amount of premiums earned in the case of individual policies.

(b) HMO loss ratio standard. An HMO loss ratio, where coverage is provided on a service rather than reimbursement basis, must be calculated on the basis of incurred claims experience or incurred health care expenses and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by an HMO may not include:

(1) home office and overhead costs;

(2) advertising costs;

(3) commissions and other acquisition costs;

(4) taxes;

(5) capital costs;

(6) administrative costs; and

(7) claims processing costs.

(c) Calendar-year experience loss ratio standard. For the most recent calendar year, the ratio of incurred losses to earned premiums for all policies or certificates that have been in force for three years or more, as of December 31st of the most recent year, must be equal to or greater than:

(1) at least 75% [~~percent~~] in the case of group policies; and

(2) at least 65% [~~percent~~] in the case of individual policies.

(d) Filing of rates and rating schedules. All filings of rates and rating schedules must demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions must also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards. For individual or group policies issued before March 1, 1992, the provisions of paragraph (3) of this subsection must be met with respect to expected claims in relation to premiums. For purposes of submitting a rate filing under this section, policy forms, whether for open or closed blocks of business, providing for similar benefits must be combined. But for purposes of the required combination set out in this section, issuers may distinguish between policy forms providing for similar benefits for individuals 65 years of age or over and policy forms providing for similar benefits for individuals under age 65. Once policy forms have been combined, they remain so for all rating purposes. When forms have been combined, a rate revision request must not differentiate between the experience of the individual forms. Where significant inconsistencies between rate levels exist among forms providing similar benefits, some deviation in rate revision must be allowed to reduce the significant inconsistencies.

(1) Each Medicare supplement policy or certificate form must be accompanied, on submission for approval, by an actuarial memorandum. The memorandum must be prepared and signed by a qualified actuary in accordance with generally accepted actuarial principles and practices, and must contain the information listed in the following subparagraphs:

(A) the form number that the actuarial memorandum addresses;

(B) a brief description of benefits provided;

(C) a schedule of rates to be used;

(D) a complete explanation of the rating process, including assumptions, claims data, methodology, and formulae used in developing the gross premium rates;

(E) a statement of what experience base will be used in future rate adjustments;

(F) a certification that the anticipated aggregate loss ratio is at least 65% [~~percent~~] (for individual coverage) or at least 75% [~~percent~~] (for group coverage), which should include a statement of the period over which the aggregate loss ratio is expected to be realized;

(G) a table of anticipated loss ratio experience for representative issue ages for each year from issue over the period during which the aggregate loss ratio is to be realized; and

(H) a certification that the premiums are reasonable in relation to the benefits provided.

(2) Subsequent rate adjustment filings, except for those rates filed solely due to a change in the Part A calendar year deductible, must also provide an actuarial memorandum, prepared by a qualified actuary in accordance with generally accepted actuarial principles and practices, which must contain the following information:

(A) the form number addressed by the actuarial memorandum;

(B) a brief description of benefits provided;

(C) a schedule of rates before and after the rate change;

(D) a statement of the reason and basis for the rate change;

(E) a demonstration and certification by the qualified actuary to show that the past plus future expected experience after the rate change, will result in an aggregate loss ratio equal to, or greater than, the required minimum aggregate loss ratio;

(i) this rate change and demonstration must be based on the experience of the named form in Texas only, if that experience is fully credible, as set out in paragraph (3) of this subsection;

(ii) this rate change and demonstration must be based on experience of the named form nationwide, with credibility factors as set out in paragraph (3) of this subsection applied, if the named form is used nationwide and the Texas experience is not fully credible;

(iii) this rate change and demonstration must be based on experience of the named form in Texas only, with credibility factors as set out in paragraph (3) of this subsection applied, if the named form is used in Texas only and the Texas experience is not fully credible;

(F) for policies or certificates in force less than three years, a demonstration to show that the third-year loss ratio is expected to be equal to or greater than the applicable percentage; and

(G) a certification by the qualified actuary that the resulting premiums are reasonable in relation to the benefits provided.

(3) For purposes of this subsection, if a group or individual policy form has 2,000 or more policies in force, then full credibility (100% [~~percent~~]) must be given to the experience. If fewer than 500 policies are in force, then no credibility (0% [~~percent~~]) must be given to the experience. The principle of linear interpolation must be used for in force numbers between 500 and 2,000. For group policy forms, the reference in this paragraph to the number of in force policies means the number of in force certificates under group policies. For purposes of this section, "in force" means either the average number of policies in force for the experience period used to support the need for a rate revision, or the number of policies in force as of the ending date of the experience period used to support the need for a rate revision. Once an issuer makes a decision as to which definition it will apply to a particular policy form, the decision is irrevocable. An issuer may submit specific alternate credibility standards to the department for consideration. In order for an alternate standard of credibility to be acceptable for application, the issuer must demonstrate that the standards are based on sound actuarial principles, and that the resulting loss ratios are in substantial compliance with the requirements of subsections (a), (b), and (c) of this section.

(4) For individual policies issued before March 1, 1992, the expected claims in relation to premiums must meet:

(A) the originally filed anticipated loss ratio when combined with the actual experience since inception;

(B) a loss ratio of at least 65% [~~percent~~] when combined with actual experience beginning with June 1, 1996, to date; and

(C) a loss ratio of at least 65% [~~percent~~] over the entire future period for which the rates are computed to provide coverage.

(e) Annual filing of premium rates required. Every issuer of Medicare supplement policies and certificates issued before or after March 1, 1992, in this state must file annually its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums, for the most recent calendar year broken down by calendar year of issue or by policy duration, for purposes of demonstrating that the issuer is in compliance with the loss ratio standards and for approval by the department in accordance with the filing requirements of this section and the requirements of §3.3323 of this title (relating to Increases to Premium Rates). The supporting documentation must also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions, that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration must exclude active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage must be demonstrated for policies or certificates in force less than three years. The annual filing requirements in this subsection must be as follows:

(1) the NAIC Medicare supplement experience exhibit, which summarizes the experience of each individual form with business in force in Texas;

(2) the NAIC Medicare supplement experience exhibit, which summarizes the experience of each group form with business in force in Texas;

(3) rates and rating schedules for each form with business in force in Texas;

(4) a certification by the qualified actuary that the policies or certificates in force less than three years are anticipated to produce a third-year loss ratio that is greater than or equal to the applicable loss ratio percentage; and

(5) a certification by the qualified actuary that the expected losses in relation to premiums over the entire period for which the policy is rated comply with the required minimum aggregate loss ratio standard.

(f) Refund or credit calculation. An issuer must perform the refund or credit calculation consistent with the instructions [~~use the online reporting form found on the department's website at www.tdi.texas.gov and electronically submit the data required by this section, which is~~] contained in Figure: 28 TAC §3.3307(f) of this section. Issuers must retain documentation supporting the calculations required by this subsection for a period of five years and provide the calculations and supporting documentation to the Commissioner on request and in the manner prescribed by the Commissioner. [~~submit the report to the department no later than May 31 of each year.~~]

Figure: 28 TAC §3.3307(f)

TEXAS DEPARTMENT OF INSURANCE
MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR THE CALENDAR YEAR _______

TYPE[1] ____SMSBP[2]________________________
For the State of Texas ____
Company Name ____
NAIC Group Code ___________________________________NAIC Company Code _____________
Address ____
Person Completing this Exhibit ____
Title ____Telephone _______________________

☐ This company did not have any Medicare supplement business written or policies or certificates in force in Texas during the reporting year.

Line		(I) Earned Premium[3]	(II) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)	_________	_________
	b. Current year's issues[5]	_________	_________
	c. Net (for reporting purposes) (line 1a - line 1b)	_________	_________
2.	Past Year's Experience (all policy years)	_________	_________
3.	Total Experience (line 1c + line 2)	_________	_________
4.	Refunds Last Year (excluding interest)	_________	
5.	Refunds From all Previous Reporting Years (excluding interest)	_________	
6.	Refunds Since Inception (excluding interest) (line 4 + line 5)	_________	
7.	Benchmark Ratio Since Inception (Ratio 1 automatically calculated from Benchmark form)	_________	

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select only. (Ensure you have chosen the correct "Type." Changing the "Type" after data has been entered in the Benchmark page will result in the deletion of all data entered in the Benchmark page.)
[2] SMSBP means Standardized Medicare Supplement Benefit Plan. Use "PS" for pre-standardized plans.
[3] Includes Modal Loadings and Fees Charged.
[4] Excludes Active Life Reserves.
[5] This will be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios."

TEXAS DEPARTMENT OF INSURANCE
MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR THE CALENDAR YEAR ________
(Continued)

TYPE [6]____SMSBP[7]_______________________
Company Name ____

8. Experienced Ratio Since Inception (Ratio 2) _________
(line 3, col. II) / (line 3, col. I - line 6)

9. Life Years Exposed Since Inception _________
If (line 8 < line 7) AND (line 9 > 499), proceed; otherwise, stop.

10. Tolerance Permitted (obtained from credibility table) _________

Medicare Supplement Credibility Table	
Life Years Exposed Since Inception	Tolerance
10,000+	0.0%
5,000 – 9,999	5.0%
2,500 – 4,999	7.5%
1,000 – 2,499	10.0%
500 – 999	15.0%
If less than 500, no credibility	

11. Adjustment to Incurred Claims for Credibility (Ratio 3) _________
(line 8 + line 10)

If (line 11 > line 7), a refund/credit is not required; otherwise, proceed.

12. Adjusted Incurred Claims _________
(line 3, col. I - line 6) x (line 11)

[6] Individual, Group, Individual Medicare Select, or Group Medicare Select only.
[7] SMSBP means Standardized Medicare Supplement Benefit Plan. Use "PS" for pre-standardized plans.

TEXAS DEPARTMENT OF INSURANCE
MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR THE CALENDAR YEAR ________
(Continued)

TYPE [8] ____ SMSBP[9] ________________________
Company Name ____

13. Refund _________
    [line 3, col. I - line 6 - (line 12 / line 7)]

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year (the de minimis amount), then there is no refund. Otherwise, the amount on line 13 will be refunded or credited, and a description of the refund or credit against premiums to be used must be provided in the Distribution Methodology field.

De minimis Amount _________
(.005 x annualized premium in force on 12/31)

Distribution Methodology

☐ By checking this box, I attest that all information contained in this form is a full and true statement in accordance with the instructions provided to the best of my information, knowledge, and belief.

____
Name

____
Title

____
Date

[8] Individual, Group, Individual Medicare Select, or Group Medicare Select only.
[9] SMSBP means Standardized Medicare Supplement Benefit Plan. Use "PS" for pre-standardized plans.

TEXAS DEPARTMENT OF INSURANCE
REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR THE CALENDAR YEAR ________

TYPE [10] ____ SMSBP[11] ________________________
Company Name ____

(a)[12]	(b)[13]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[14]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
		2.770		0.442		0.000		0.000		0.40
		4.175		0.493		0.000		0.000		0.55
		4.175		0.493		1.194		0.659		0.65
		4.175		0.493		2.245		0.669		0.67
		4.175		0.493		3.170		0.678		0.69
		4.175		0.493		3.998		0.686		0.71
		4.175		0.493		4.754		0.695		0.73
		4.175		0.493		5.445		0.702		0.75
		4.175		0.493		6.075		0.708		0.76
		4.175		0.493		6.650		0.713		0.76
		4.175		0.493		7.176		0.717		0.76
		4.175		0.493		7.655		0.720		0.77
		4.175		0.493		8.093		0.723		0.77
		4.175		0.493		8.493		0.725		0.77
		4.175		0.493		8.684		0.725		0.77
Total:		(k):		(I):		(m):		(n):		

Benchmark Ratio Since Inception: (l+n) / (k+m): ____________ (Ratio 1)

[10] Individual, Group, Individual Medicare Select, or Group Medicare Select only.
[11] SMSBP means Standardized Medicare Supplement Benefit Plan. Use "PS" for pre-standardized plans.
[12] Data entered must be for the calendar year displayed.
[13] For the calendar year on the appropriate line in column (a), the premium earned during that year is for policies issued in that year.
[14] These loss ratios are not explicitly used in computing the benchmark ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

TEXAS DEPARTMENT OF INSURANCE
REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR THE CALENDAR YEAR _______

TYPE [15]____SMSBP[16]______________________
Company Name ____

(a)[17]	(b)[18]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[19]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
		2.770		0.507		0.000		0.000		0.46
		4.175		0.567		0.000		0.000		0.63
		4.175		0.567		1.194		0.759		0.75
		4.175		0.567		2.245		0.771		0.77
		4.175		0.567		3.170		0.782		0.80
		4.175		0.567		3.998		0.792		0.82
		4.175		0.567		4.754		0.802		0.84
		4.175		0.567		5.445		0.811		0.87
		4.175		0.567		6.075		0.818		0.88
		4.175		0.567		6.650		0.824		0.88
		4.175		0.567		7.176		0.828		0.88
		4.175		0.567		7.655		0.831		0.88
		4.175		0.567		8.093		0.834		0.89
		4.175		0.567		8.493		0.837		0.89
		4.175		0.567		8.684		0.838		0.89
Total:		(k):		(I):		(m):		(n):		

Benchmark Ratio Since Inception: (l+n) / (k+m): ____________ (Ratio 1)

[15] Individual, Group, Individual Medicare Select, or Group Medicare Select only.
[16] SMSBP means Standardized Medicare Supplement Benefit Plan. Use "PS" for pre-standardized plans.
[17] Data entered must be for the calendar year displayed.
[18] For the calendar year on the appropriate line in column (a), the premium earned during that year is for policies issued in that year.
[19] These loss ratios are not explicitly used in computing the benchmark ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

~~Insurance Company Name~~ ______________________________

~~Form Numbers for Medicare Supplement Refund Calculation~~
~~for Plan~~ ____________________

~~Please enter only one form number per line.~~	~~Please enter only one form number per line.~~

~~Print Form~~ ~~Submit by Email~~

(1) If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation must be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year must be excluded.

(2) A refund or credit will be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund must include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary, but in no event may it be less than the average rate of interest for 13-week treasury notes. A refund or credit against premiums due must be made by September 30 following the experience year on which the refund or credit is based.

(3) For an individual or group policy or certificate issued before March 1, 1992, the issuer, for purposes of complying with this subsection, must make the refund or credit calculation separately for all individual policies combined and all group policies combined for experience after June 1, 1996.

(g) Premium adjustments to conform with minimum standards for loss ratios. As soon as practicable, but before the effective date of enhancements to Medicare benefits, every issuer of Medicare supplement insurance policies, contracts, or coverage in this state must file with the Commissioner, in accordance with the applicable filing procedures of this state, the items required in paragraphs (1) and (2) of this subsection.

(1) Issuers must file the appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or contracts. Documents necessary to justify the adjustment must accompany the filing.

(A) Every issuer of Medicare supplement insurance or benefits to a resident of this state under Insurance Code Chapter 1652 must make premium adjustments:

(i) necessary to produce an expected loss ratio under the policy or contract that will conform with the minimum loss ratio standards for Medicare supplement policies; and

(ii) expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premium by the issuer for the Medicare supplement insurance policies or contracts.

(B) No premium adjustment that would modify the loss ratio experience under the policy, other than the adjustments described in this subsection, should be made with respect to a policy at any time other than on its renewal date or anniversary date.

(C) If an issuer fails to make premium adjustments that are acceptable to the Commissioner, the Commissioner may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by this section.

(2) Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare must be filed. The riders, endorsements, or policy forms must provide a clear description of the Medicare supplement benefits provided by the policy or contract.

(h) Maintenance of data. Incurred claims and earned premium experience must be maintained for each policy form with business in force in Texas, by calendar year of issue, and must be made available to the department.

CERTIFICATION. This agency certifies that legal counsel has reviewed the proposal and found it to be within the agency's authority to adopt.

Issued in Austin, Texas, on April 5, 2021.

DocuSigned by:
James Person
75578E954EFC48A...

James Person, General Counsel
Texas Department of Insurance