

Subchapter T. Minimum Standards for Medicare Supplement Policies
28 TAC §§3.3309, 3.3312, and 3.3324

INTRODUCTION. The Texas Department of Insurance (TDI) proposes to amend 28 TAC §§3.3309, 3.3312, and 3.3324, concerning requirements for Medicare supplement coverage. The proposed amendments implement House Bill 2516, 89th Legislature, 2025.

EXPLANATION. The amendments to §§3.3309, 3.3312, and 3.3324 are necessary to implement HB 2516, which added Insurance Code §1652.059 and §1652.060, requiring that individuals younger than 65 who become enrolled in Medicare by reason of end stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS) be given access to the same coverage, and in some cases at the same rates, as those offered to individuals 65 and older. The amendments also clarify the existing language and protections regarding guaranteed issuance and the rating of disabled enrollees when they turn 65, which were discussed in Bulletin #B-0027-21 (available online at www.tdi.texas.gov/bulletins/2021/B-0027-21.html).

Descriptions of the sections' proposed amendments follow.

Section 3.3309. Proposed amendments to subsection (a)(1) remove language from subparagraphs (D) and (E) related to coverage for outpatient prescription drugs. Those provisions were included to implement the Medicare Prescription Drug Improvement and Modernization Act of 2003 but are no longer relevant.

Proposed amendments to subsection (b) require that Medicare supplement applications elicit information as to whether someone younger than 65 qualifies under HB 2516. These changes are necessary to ensure that issuers have the information to comply with the new requirements. The amendments also delete extraneous language from the subsection.

Proposed amendments to Figure: 28 TAC §3.3309(f) remove a reference to enrollment in Part D, which is no longer needed, and remove unnecessary underlines.

A proposed amendment to subsection (g) revises a reference in the rule text that incorrectly refers to parts of Figure: 28 TAC §3.3309(f) as paragraphs of subsection (f).

Proposed amendments also include nonsubstantive rule drafting and formatting changes for plain language and to conform to the agency's current style and improve clarity. For example, "shall" is changed to "must" throughout the rule text, and "preexisting conditions" is changed to "preexisting condition limitations."

Section 3.3312. The title of this section is proposed to be amended to add a reference "Notice Requirements" in light of the notification requirement found in new subsection (f) of this section.

Proposed amendments to subsection (a)(1) reference that individuals will indicate on their application that they meet the section's eligibility requirements and submit evidence of eligibility as necessary. An extraneous "and" is deleted in subsection (a)(2).

Proposed amendments to subsection (b) delete paragraphs (7) and (9) relating to enrollment in Medicare Part D and the Texas Health Insurance Pool, as the references in these paragraphs are obsolete and unnecessary, and renumber current paragraph (8) as paragraph (7). New subsection (b)(8) identifies for purposes of other amendments individuals meeting the requirements of Insurance Code §1652.059 and enrolled in Medicare before the effective date of the rule amendments.

An amendment in subsection (c)(1) revises a reference to the paragraphs in subsection (b) to reflect the changes to the paragraphs in that subsection. Subparagraphs (A) and (B) in subsection (c)(1) are amended to implement HB 2516 by clarifying that individuals eligible under that bill are entitled to the same plans that anyone turning 65 is eligible for. To conform to the deletion of subsection (b)(7), subsection (c)(2) is amended

to remove provisions related to the removal of prescription drug coverage, and subsection (c)(4) is deleted.

Proposed new subsection (c)(4) implements the protections of HB 2516 by providing that individuals eligible under that bill are entitled to the same plans offered to others by the issuer and may not be subject to separate forms or rates.

An amendment is proposed to delete current subsection (d)(5) to conform to the deletion of subsection (b)(7). Subsequent paragraphs are renumbered.

Subsection (d)(6) is amended to delete the reference to the Texas Health Insurance Pool, as it is obsolete. In accordance with Insurance Code §1652.060(d), which authorizes the commissioner to designate enrollment periods by rule, new text is added in subsection (d)(6) to provide a guaranteed issue period for those eligible under HB 2516 from October 15, 2026, through March 31, 2027. This aligns with Medicare open enrollment periods to support individuals who may switch from a Medicare Advantage plan to traditional Medicare and want to purchase Medicare supplement coverage.

Proposed new subsection (f) requires issuers to provide timely notice to those eligible for the enrollment period created by subsection (d)(6). This will ensure that those eligible under HB 2516 receive notice of their opportunity to realize the benefits of that legislation.

In addition, the proposed amendments include nonsubstantive rule drafting and formatting changes for plain language and to conform the section to the agency's current style and improve clarity. For example, "in accordance with" is changed to "according to," and edits are made to paragraph organization for clarity.

Section 3.3324. Proposed amendments to subsection (a) make clarifying changes to implement HB 2516. The changes relate to medical underwriting and exceptions to the required availability of Medicare supplement policies and certificates.

Proposed amendments to subsection (b)(1) are necessary to distinguish between requirements for individuals younger than 65 who are eligible under HB 2516 and those who are not.

Proposed amendments to subsection (b)(2) clarify that an individual turning 65 who previously obtained Medicare supplement coverage due to disability and early enrollment in Medicare has the same rights to obtain Medicare supplement coverage at age 65 as anyone else turning 65. If an individual chooses to remain with their plan, they must be charged the same premium as someone enrolling for the first time at age 65.

Proposed new subsection (b)(3) requires notice (beginning 90 days after the effective date of the section) to those enrollees turning 65 of any premium adjustment and new open enrollment period under subsection (b)(2). These changes are consistent with TDI's 2021 Bulletin #B-0027-21 (online at www.tdi.texas.gov/bulletins/2021/B-0027-21.html), which cited CMS' December 2002 guidance, Transmittal No. 02-03 (available online at www.cms.gov/Medicare/Health-Plans/Medigap/Downloads/mdgp0203.pdf), requiring a second open enrollment opportunity at age 65 for Medicare supplement policyholders who obtained coverage before 65 because of disability.

Proposed new subsection (b)(4) implements the requirements of HB 2516 by requiring that qualifying individuals be charged the same rates as others for some plans and no more than 200% of the rates charged others for other plans. It also prohibits application of preexisting condition exclusions or waiting periods to these qualifying individuals.

Proposed new subsection (b)(5) provides that issuers filing for rate increases before January 1, 2028, in which they rely on HB 2516 as justification for the rate increase, must also affirm that the rates for those individuals that do not qualify under HB 2516 will continue to meet the loss ratio standards of 28 TAC §3.3307. This will assist TDI's review of rate increase requests and ensure compliance with rating requirements. In particular,

TDI is concerned about cases in which issuers reexamine their rates and increase them when eligible individuals are moved into the larger risk pool of those who become eligible for Medicare at age 65. In those cases, the rates of those individuals younger than 65 who are not eligible under HB 2516 and who remain in a separate risk pool that now no longer includes individuals with ESRD or ALS should also be reexamined to ensure they are not excessive.

In addition, the proposed amendments include nonsubstantive rule drafting and formatting changes for plain language and to conform the section to the agency's current style and improve clarity.

TDI received comments on an informal draft posted on TDI's website on September 4, 2025. TDI considered those comments when drafting this proposal.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, director of Regulatory Initiatives in 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 amendments, other than that imposed by statute. Ms. Bowden 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. Bowden 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. Bowden expects that enforcing them will have the public benefits of ensuring that both TDI's rules and Medicare supplement policies in Texas

conform to Insurance Code Chapter 1652 and that consumers with Medicare supplement policies in Texas have the broadest possible options in coverage and rates.

Regarding the proposed HB 2516 amendments, Ms. Bowden expects that the proposed amendments will not increase the cost of compliance for regulated persons because the amendments would not impose requirements beyond those in statute. Insurance Code §1652.059 requires that the same coverage be offered to those younger than 65 enrolled in Medicare by reason of ESRD or ALS as is offered to those 65 or older. The amendments to §3.3309(b), for example, requiring that such eligibility information be elicited, are necessary for issuers to comply with §1652.059. Amendments to §3.3312 and §3.3324 similarly modify the rules to conform to HB 2516. The amendment to §3.3324(b)(5) requiring an actuary to confirm that the rates of those younger than 65 are compliant should not add any measurable cost because issuers are already subject to the loss ratio standards under 28 TAC §3.3307, which would require such an analysis.

Proposed new §3.3312(d)(6) and (f) require notice of a guaranteed issue period for those eligible under HB 2516. Ms. Bowden expects that this could impose an economic cost on persons required to comply because issuers will have to prepare and issue a notice to current insureds regarding the guaranteed issue period and then modify the coverage of responding eligible insureds to comply with HB 2516. If an issuer uses electronic delivery as permitted under Insurance Code Chapter 35, the issuer may send the notices electronically, avoiding paper and printing costs.

If an issuer prints paper copies instead, TDI expects the cost to be between \$0.06 and \$0.08 per page for printing and paper. An issuer's cost of complying with the requirements will depend on whether the mailing may be included with other information sent to policyholders. TDI expects that each issuer will have the information necessary to determine its individual cost, including in-house printing costs and commercial printing

costs. TDI estimates that issuers may face administrative costs associated with creating and sending the notice.

While it is not feasible to determine the actual cost of any employees needed to comply with the requirement, TDI estimates that creating and sending the notice may require the following resources: between eight and 14 hours of compliance officer staff time to create the notice and create processes to effectuate changes to enrollment, and between eight and 14 hours of computer programming staff time to prepare and test systems to begin distributing the notice. Staff costs may vary depending on the skill level required, the number of staff required, and the geographic location where work is done. The 2024 median hourly wage for these positions in Texas was: compliance officer, \$34.64; and computer programmer, \$38.85; as reported by the Texas Wages and Employment Projections database, which is developed and maintained by the Texas Workforce Commission and located at www.texaswages.com/WDAWages.

Proposed new §3.3324(b)(2) and (3) provide that individuals with coverage before age 65 who turn 65 must be given the same rates as those who enroll at age 65 for the first time and receive notice and an opportunity to change plans. Issuers already appear to be providing the opportunity to change plans due to prior federal and TDI guidance, but there could be a cost to issuers to automatically change rates at age 65 and provide notice of the opportunity to change plans. While it is not feasible to determine the actual cost of any employees needed to comply with the requirement, TDI estimates that creating the notice may require five to 10 hours of compliance officer staff time to create the notice and create processes to effectuate changes to enrollment; and between eight and 14 hours of computer programming staff time to prepare and test systems to distribute the notice and to effectuate changes to enrollment. Because the rule permits the issuer to send the notice any time during the year when the individual is 64, the notice should be able to be sent with other correspondence at no additional cost.

TDI posted an informal draft substantially similar to this proposal on September 4, 2025 (online at www.tdi.texas.gov/rules/documents/33309webcover.pdf).

TDI's posting included the following request for cost information: "TDI seeks input on this draft rule, including input from industry on any costs associated with complying with the informal rule text that are not imposed by the statute. This input will inform the analyses that TDI must include under Government Code Chapter 2001 when it prepares the formal rule proposal. TDI believes that the industry is already complying with most of the provisions in the draft or that any costs not required by HB 2516 would be minimal. If you feel this is wrong, please provide your input to help us understand the additional costs."

No commenter provided information on costs other than a general reference to "administrative burden." Nevertheless, TDI modified the draft text as incorporated into this proposal by giving issuers additional time to implement notification requirements. This change further minimizes the administrative cost to issuers.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed amendments may have a minimal adverse economic effect on issuers that are small or micro businesses. The cost analysis in this proposal's Public Benefit and Cost Note section also applies to these small and micro businesses. TDI estimates that the proposed amendments may affect less than 10 issuers that are small or micro businesses. The primary objectives of this proposal are to implement HB 2516 and its protections for under-65 Medicare-eligible individuals and to provide protections for those turning 65 who are already enrolled in a Medicare supplement policy. TDI considered the following alternatives to minimize any adverse impact on small and micro businesses while accomplishing the proposal's objectives:

(1) entirely declining to propose, or postponing the implementation of, some requirements that might impose costs on small and micro issuers;

(2) giving small and micro issuers additional time to come into compliance with the rule amendments; and

(3) exempting small and micro issuers from some of the rule amendments.

Regarding alternative (1), TDI made changes from the draft text that it posted in September to reduce administrative costs on all issuers by giving issuers additional time to implement notification requirements. This change may also reduce the administrative costs to small and micro issuers.

TDI rejected alternative (2), providing additional time to small and micro issuers, because the requirements of the proposed amendments are either required by statute or involve timeframes for notification to insureds that would be ineffective if postponed or would cause confusion in the market if different timeframes applied to different issuers.

TDI similarly rejected alternative (3), exempting small and micro issuers from some of the proposed requirements, because many of the proposed amendments are required by statute, which contains no exemption for small or micro issuers, or are necessary for the protection of all insureds, regardless of their issuer's size.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal might impose a possible cost on regulated persons. However, no additional rule amendments are required under Government Code §2001.0045, in part because, as discussed, the proposed rule text is necessary to implement legislation. The proposed rule implements Insurance Code §1652.059 and §1652.060, as added by HB 2516.

Proposed new §3.3312(d)(6) and (f) require notice of a guaranteed issue period for those newly eligible under HB 2516. Ms. Bowden expects that this could impose an

economic cost on persons required to comply because issuers will have to prepare and issue a notice to current insureds about the guaranteed issue period and then modify the coverage of those responding eligible insureds to comply with HB 2516. Government Code §2001.0045 does not apply to these amendments because they are necessary to implement legislation.

Specifically, new Insurance Code §1652.060(d), under HB 2516, provides that "[t]he commissioner shall adopt rules as necessary to administer this section, including rules designating enrollment periods." While HB 2516 does not explicitly mention notice to insureds of their enrollment opportunities, Insurance Code §1652.051 requires the commissioner to adopt reasonable standards for facilitating comparisons of different Medicare supplement benefit plans which may include "provisions relating to . . . initial and subsequent conditions of eligibility." Notice to insureds of their eligibility to change plans is essential to facilitating their comparison of those plans and is necessary to administer new §1652.060.

Proposed new §3.3324(b)(2) and (3) provide that individuals with coverage before age 65 who turn 65 must be given the same rates as those who enroll at age 65 for the first time and receive notice and an opportunity to change plans. Issuers already appear to be providing the opportunity to change plans due to prior federal and TDI guidance. See www.cms.gov/Medicare/Health-Plans/Medigap/Downloads/mdgdp0203.pdf.

This opportunity to change plans is required by federal law, and Insurance Code §1652.005 requires that TDI adopt rules necessary to retain certification as a state with an approved regulatory program. Also, Insurance Code §1652.051 requires the commissioner to adopt reasonable rules, which may include provisions relating to initial and subsequent conditions of eligibility. Further, Government Code §2001.0045(c)(4) provides that the requirements of that section do not apply to a rule that is necessary to comply with federal law. The additional provisions requiring re-rating and notice are also necessary to

implement the requirement in Insurance Code §1652.051 to adopt rules facilitating comparisons of different Medicare supplement benefit plans, including "provisions relating to . . . initial and subsequent conditions of eligibility." They are also necessary to protect the health, safety, and welfare of vulnerable senior residents of this state.

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 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 June 17, 2026. Consistent with Government Code §2001.024(a)(8), TDI requests public comments on the proposal, including information related to the cost, benefit, or effect of the proposal and any applicable data, research, and analysis. 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.

The commissioner of insurance will also consider written and oral comments on the proposal in a public hearing under Docket No. 2867. This proposal will be part of a rule hearing docket that will begin at 1:00 p.m., central time, on June 15, 2026. TDI will hold the public hearing remotely using online resources and in person at the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin Texas 78701 in Room 2.029. Visit www.tdi.texas.gov/alert/event/index.html for more info on the proposed rule, hearing, and comment submission.

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STATUTORY AUTHORITY. TDI proposes amendments to §§3.3309, 3.3312, and 3.3324 under Insurance Code §§1652.005, 1652.051, 1652.060, 1652.101, 1652.103, 1701.060, and 36.001.

Insurance Code §1652.005 requires the commissioner to adopt reasonable rules necessary and proper to carry out Insurance Code Chapter 1652, including rules necessary to retain federal certification as a state with an approved regulatory program.

Insurance Code §1652.051 requires the commissioner to adopt reasonable rules to establish standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons between different Medicare supplement plans. The standards

may include provisions relating to initial and subsequent conditions of eligibility. These rules may also include reasonable rules that specifically prohibit plan provisions that are not otherwise specifically authorized by statute and that the commissioner determines are unjust, unfair, or unfairly discriminatory.

Insurance Code §1652.060 requires the commissioner to adopt rules as necessary to administer that section, including rules designating enrollment periods.

Insurance Code §1652.101 requires the commissioner to adopt reasonable rules to establish minimum loss ratio standards for Medicare supplement plans.

Insurance Code §1652.103 requires the commissioner by rule to provide a process for reviewing and approving or disapproving a proposed premium increase relating to Medicare supplement plans.

Insurance Code §1701.060 gives the commissioner general rulemaking authority to adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including rules that establish procedures and criteria under which forms will be reviewed.

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. Amendments to §3.3309 implement Insurance Code §1652.059. Amendments to §3.3312 and §3.3324 implement Insurance Code §§31.002, 1652.005, 1652.051, 1652.059, 1652.060, 1652.101, 1652.103, and 1701.060.

TEXT.

§3.3309. Requirements for Application Forms and Replacement Coverage.

(a) Application forms must [~~shall~~] include the following information, statements, and questions designed to elicit information as to whether, as of the date of the application, the applicant currently has another Medicare supplement, Medicare Advantage, Medicaid coverage, or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate currently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used.

(1) The information must [~~shall~~] be provided to prospective covered persons in statement form conforming to subparagraphs (A) - (F) of this paragraph.

(A) You do not need more than one Medicare supplement policy.

(B) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.

(C) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(D) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. [~~If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug~~]

~~coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.]~~

(E) If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. ~~[If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.]~~

(F) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

(2) Information must ~~[shall]~~ be elicited from prospective covered persons by asking the following questions ~~[as follows]~~: If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer

with your application. PLEASE ANSWER ALL QUESTIONS. Please mark Yes or No below with an "X" to the best of your knowledge.

(A) Did you turn age 65 in the last 6 months? Yes___ No___

(B) Did you enroll in Medicare Part B in the last 6 months? Yes___

No___

(C) If yes, what is the effective date?

(D) Are you covered for medical assistance through the state Medicaid program?

(i) {NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.} Yes___ No___

(ii) If yes;

(I) Will Medicaid pay your premiums for this Medicare supplement policy? Yes___ No___

(II) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes___ No___

(E) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START __/__/__ END __/__/__

(i) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes___ No___

(ii) Was this your first time in this type of Medicare plan? Yes___ No___

(iii) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes___ No___

(F) Do you have another Medicare supplement policy in force? Yes___ No___

(i) If so, with what company, and what plan do you have {optional for Direct Mailers}?

(ii) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes___ No___

(G) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) Yes___ No___

(i) If so, with what company and what kind of policy?

(ii) What are your dates of coverage under the other policy? START __/__/__ END __/__/__ (If you are still covered under the other policy, leave "END" blank.)

(b) Application forms must ~~[shall]~~ include questions to elicit information as to whether the applicant qualifies under Insurance Code §1652.059, concerning Coverage for Certain Individuals Younger Than 65, is an eligible person as defined in §3.3312(b) of this title (relating to Guaranteed Issue for Eligible Persons; Notice Requirements), or ~~[whether the applicant]~~ is eligible for reduction of any applicable preexisting condition limitation under §3.3324(c) and (d) of this title (relating to Open Enrollment).

(c) Agents must list ~~[shall list the following]~~:

(1) any other health insurance policies or coverages sold to the applicant that ~~[which]~~ are still in force; and

(2) any other health insurance policies or coverages sold to the applicant in the past five years that ~~[which]~~ are no longer in force.

(d) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant[,] and acknowledged by the issuer, must ~~[shall]~~ be returned to the applicant by the issuer upon delivery of the policy.

(e) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, must ~~[shall]~~ furnish a notice regarding replacement of Medicare supplement coverage to the applicant[,] before ~~[prior to]~~ issuance or delivery of the Medicare supplement policy or certificate~~[, a notice regarding replacement of Medicare supplement coverage]~~. One copy of the ~~[such]~~ notice signed by the applicant and the agent, except where the coverage is sold without an agent, must ~~[shall]~~ be provided to the applicant, and an additional signed copy must ~~[shall]~~ be retained by the issuer. A direct response issuer must ~~[shall]~~ deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(f) The notice required by subsection (e) of this section must ~~[shall]~~ be provided in substantially the following form and must ~~[shall]~~ be in a typeface no smaller than 12-point type.

Figure: 28 TAC §3.3309(f)

**NOTICE TO APPLICANT REGARDING
REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR
MEDICARE ADVANTAGE**

(Issuer's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to (your application) (information you have furnished), you intend to terminate existing Medicare supplement or Medicare Advantage coverage and replace it with a policy to be issued by (Issuer's Name). Your new policy will provide 30 days within which

you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY ISSUER (OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reasons:

_____ Additional benefits,

_____ Same benefits but lower premiums,

_____ Fewer benefits and lower premiums, and/or

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]

_____ Other(specify)_____.

I call to your attention the following items for your consideration:

(1) Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions waiting periods, elimination periods, or probationary periods. The insurer will reduce any time periods applicable to preexisting conditions waiting periods,

elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.

(3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the issuer to deny any future claims and to refund your premium as though the policy had never been in force. After the application has been completed and before you sign it, read and review it carefully to be certain that all information has been properly recorded.

(4) Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Agent or Other Representative

Typed Name and Address of Issuer or Agent

(Applicant's Signature)

(Date)

(g) The items found in paragraphs (1) and (2) of Figure: 28 TAC §3.3309(f) apply to preexisting condition limitations and [Subsection (f)(1) and (2) of this section (applicable to preexisting conditions)] may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

§3.3312. Guaranteed Issue for Eligible Persons; Notice Requirements.

(a) Guaranteed issue.

(1) Eligible persons are those individuals described in subsection (b) of this section who seek to enroll under the Medicare supplement policy during the period specified in subsection (d) of this section, who indicate on the application for a Medicare supplement policy that they meet the requirements of this section, and who submit evidence of eligibility as necessary, such as the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer must not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (c) of this section that is offered and is available for issuance to newly enrolled individuals by the issuer; ~~and~~ must not discriminate in the pricing of a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; ~~and~~ and must not impose an exclusion of benefits based on a preexisting condition under a Medicare supplement policy.

(b) Eligible persons. An eligible person is an individual described in any of the following paragraphs. ~~and~~

(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 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 because the individual leaves the plan.

(2) 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 age 65 ~~[years of age]~~ or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under §1894 of the Social Security Act, and there are circumstances similar to the following 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;

[or]

(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 §1851(g)(3)(B) of the 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 §1856), or the plan is terminated for all individuals within a residence area;

(D) the individual demonstrates, according to [~~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 42 U.S.C. Chapter 7, Subchapter XVIII, Part D₁ in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care according to [~~in accord with~~] applicable quality standards; or

(ii) the organization, [or] agent, or other entity acting on the organization's behalf_[r] materially misrepresented the plan's provisions in marketing the plan to the individual; or

(E) the individual meets other exceptional conditions as the Secretary may provide.

(3) The individual is enrolled with an entity listed in subparagraphs (A) - (D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) of this subsection:

(A) an eligible organization under a contract under §1876 of the Social Security Act (Medicare cost);

(B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

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

(D) an organization under a Medicare Select policy.~~]; and~~

(4) The ~~the~~ individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(A) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or 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, an agent, or other entity acting on the issuer's behalf~~]~~ materially misrepresented the policy's provisions in marketing the policy to the individual.~~]~~

(5) The ~~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 §1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE

provider under §1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which time the individual is permitted to terminate the subsequent enrollment under §1851(e) of the Social Security Act).~~[-or]~~

(6) The ~~the~~ individual, on first becoming enrolled in Medicare Part B ~~for benefits at age 65 or older~~, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under §1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

~~[(7) 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 subsection (c)(4) of this section.]~~

(7) ~~[(8)]~~ The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

(8) The individual meets the criteria in Insurance Code §1652.059, concerning Coverage for Certain Individuals Younger than 65, and enrolled in Medicare Part B before the effective date of this section.

~~[(9) The individual meets the following requirements:]~~

~~[(A) the individual was enrolled in both the federal Medicare program and the Texas Health Insurance Pool on December 31, 2013; and]~~

~~[(B) the individual's Pool coverage terminated on or after December 31, 2013.]~~

(c) Products that ~~to which~~ eligible persons are entitled to.

(1) Persons described by subsection (b)(1), (2), (3), (4), and (7) ~~[(8), and (9)]~~ of this section are entitled to a Medicare supplement policy that has a benefit package classified as follows:

(A) Plan A, B, C, F (including F with a High Deductible), K, or L offered by any issuer, for an individual age 65 ~~[years of age]~~ or older, or an individual who meets the criteria in Insurance Code §1652.059, who first became eligible for Medicare before January 1, 2020, except that for persons under age 65 ~~[years of age]~~ who do not meet the criteria in Insurance Code §1652.059, it is a policy that has a benefit package classified as Plan A; or

(B) Plan A, B, D, G (including G with a High Deductible), K, or L offered by any issuer, for a 2020 newly eligible individual who is age 65 ~~[years of age]~~ or older or meets the criteria in Insurance Code §1652.059, except that for persons under age 65 ~~[years of age]~~ who do not meet the criteria in Insurance Code §1652.059, it is a policy that has a benefit package classified as Plan A.

(2) Persons described by subsection (b)(5) of this section are entitled to the same Medicare supplement policy in which the individual was most recently enrolled, if available from the same issuer or, if not available, a policy described in paragraph (1) of this subsection. ~~[If the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, the Medicare supplement policy described in this paragraph is the policy available from the same issuer but modified to remove outpatient prescription drug coverage, or at the election of the policyholder, a policy described in paragraph (1) of this subsection.]~~

(3) Persons described by subsection (b)(6) of this section are entitled to any Medicare supplement policy offered by any issuer, with the exception of Plans ~~[plans]~~ C or F (including F with a High Deductible) for a 2020 newly eligible individual.

(4) Persons described by subsection (b)(8) of this section are entitled to enroll in any plan type that is offered by any issuer, provided that:

(A) an issuer is not permitted to make Plans C or F (including F with a High Deductible) available to a 2020 newly eligible individual;

(B) coverage must be issued according to terms provided in Insurance Code §1652.060, concerning Enrollment Period for Certain Individuals Younger Than 65; and

(C) notwithstanding §3.3307(d) of this title (relating to Loss Ratio Standards and Refund or Credit of Premiums) and §3.3322(d) of this title (relating to Filing and Approval of Policies, Certificates and Premium Rates; Discontinuance of Forms), an issuer may not have a separate form or rates for persons described by subsection (b)(8) of this section.

~~[(4) Persons described by subsection (b)(7) of this section are entitled to a Medicare supplement policy that has a benefit package classified as follows:]~~

~~[(A) Plan A, B, C, F (including F with a High Deductible), K, or L, 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, for an individual who first became eligible for Medicare before January 1, 2020; or]~~

~~[(B) Plan A, B, D, G (including G with a High Deductible), K, or L, 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, for a 2020 newly eligible individual.]~~

(d) Guaranteed issue time period.

(1) In the case of an individual described in subsection (b)(1) of this section:

(A) for a plan that supplements the benefits under Medicare, the guaranteed issue period begins on the later of:

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

(ii) the date the applicable coverage terminates or ceases; ~~and ends 63 days later;~~ or

(B) for a plan that is primary to the benefits under Medicare, the guaranteed issue period begins on the later of:

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

(ii) the date the applicable coverage terminates or ceases; and ~~[ends 63 days later.]~~

(C) the guaranteed issue period ends 63 days after the date the applicable coverage terminates or ceases.

(2) In the case of an individual described in subsection (b)(2), (3), (5), or (6) of this section 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.

(3) In the case of an individual described in subsection (b)(4)(A) of this section, the guaranteed issue period begins on the earlier of 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 the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(4) In the case of an individual described in subsection (b)(2), (4)(B) and (C), (5), or (6) of this section, 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 of disenrollment.

~~[(5) In the case of an individual described in subsection (b)(7) of this section, the guaranteed issue period begins on the date the individual receives notice under §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.]~~

(5) ~~[(6)]~~ In the case of an individual described in subsection (b) of this section, but not described in paragraphs (1) - (5) 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 of disenrollment.

(6) ~~[(7)]~~ In the case of an individual described in subsection (b)(8) ~~[(b)(9)]~~ of this section, the guaranteed issue period is October 15, 2026, through March 31, 2027. ~~[begins on the date that the individual's coverage in the Texas Health Insurance Pool terminates and ends 63 days later.]~~

(e) Extended Medicare supplement access for interrupted trial periods.

(1) In the case of an individual described in subsection (b)(5) of this section (or deemed to be so described under this paragraph), whose enrollment with an organization or provider described in subsection (b)(5) of this section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider, the subsequent enrollment will be deemed to be an initial enrollment as described in subsection (b)(5) of this section.

(2) In the case of an individual described in subsection (b)(6) of this section (or deemed to be so described under this paragraph), whose enrollment with a plan or in a program described in subsection (b)(6) of this section is involuntarily terminated within

the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another plan or program, the subsequent enrollment will be deemed to be an initial enrollment as described in subsection (b)(6) of this section.

(3) For purposes of subsection (b)(5) and (6) of this section, no enrollment of an individual with an organization or provider described in subsection (b)(5) of this section, or with a plan or in a program described in subsection (b)(6) of this section, may be deemed to be an initial enrollment under this paragraph after the two-year [~~2-year~~] period beginning on the date that [~~on which~~] the individual first enrolled with the organization, provider, plan, or program.

(f) Notification of enrollment period for certain individuals under age 65. For an insured described by subsection (b)(8) of this section who enrolled in a Medicare supplement policy before the effective date of this section, the issuer must provide notice not earlier than September 1, 2026, and not later than October 15, 2026, informing the insured of the right to change plans during the enrollment period provided in subsection (d)(6) of this section.

§3.3324. Open Enrollment.

(a) Except as otherwise provided in this section, no [~~No~~] issuer may deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, subject an applicant to medical underwriting, 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 where an application for a policy or certificate is submitted before or during the six-month period beginning with the first day of the first month in which an individual is first enrolled for benefits under Medicare Part B. No issuer may engage in a premium rating practice that results in higher premiums for any policy solely because the policy is issued under the

provisions of this section. An issuer must make available [~~For individuals 65 years of age or older when first enrolled for benefits under Medicare Part B who apply for Medicare supplement coverage under this subsection,~~] each Medicare supplement policy and certificate [~~currently available from an issuer must be made available~~] to all applicants who apply for coverage under this section without regard to age, subject to the following exceptions:[-]

(1) an issuer may not make Plans C or F (including F with a High Deductible) available to a 2020 newly eligible individual;

(2) an issuer may not make available a policy or certificate that has been discontinued under §3.3322 of this title (relating to Filing and Approval of Policies, Certificates and Premium Rates; Discontinuance of Forms); and

(3) an issuer may limit availability as permitted in subsection (b) of this section.

(b) The provisions [~~of paragraphs (1) and (2)~~] of this subsection apply to Medicare supplement issuers with respect to persons who qualify for Medicare before age 65 [~~attaining 65 years of age~~].

(1) For individuals who do not qualify under Insurance Code §1652.059, concerning Coverage for Certain Individuals Younger Than 65, an issuer must make available, at a minimum, Plan A of the standard Medicare supplement plans to an individual who qualifies under this subsection and may establish a separate form and rating class as permitted under §3.3322 of this title for similarly situated individuals who enroll in Plan A under this section. [~~An issuer must comply with the first two sentences of subsection (a) of this section with respect to a person who:~~]

[(A) qualifies for Medicare before attaining 65 years of age, who first enrolls for benefits under Medicare Part B on or after January 1, 1997, and who applies

~~for a Medicare supplement policy or certificate during the period of eligibility described in subsection (a) of this section; or]~~

~~[(B) 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 subsection (a) of this section that would apply if the person first enrolled in Medicare Part B on attaining 65 years of age.]~~

(2) When an individual who is enrolled in a plan under this subsection reaches age 65, the individual is entitled to an open enrollment period under subsection (a) of this section as if the individual had enrolled in Medicare Part B on their 65th birthday, and the issuer must begin charging the premium rate that would apply to a new applicant under subsection (a) of this section. [An issuer must make available, at a minimum, Plan A of the standard Medicare supplement plans to individuals who qualify under this subsection.]

(3) On or after 90 days after the effective date of this section, an issuer covering an individual enrolled in a plan under this subsection must give notice to the individual not earlier than the individual's 64th birthday and not later than the individual's 65th birthday of the adjustment to the premium and the new open enrollment period required by this section.

(4) The provisions of this paragraph apply to individuals who qualify under Insurance Code §1652.059.

(A) For standardized Medicare supplement Plans A, B, and D, the issuer must charge a qualifying individual the same premium rate that is charged to an individual age 65 for the same plan, at the time of issuance and for the duration that the individual enrolled in the plan is under age 65.

(B) For standardized Medicare supplement plans other than Plans A, B, or D, the issuer must charge a qualifying individual a premium rate that is no higher

than 200% of the rate charged to an individual age 65 for the same plan, at the time of issuance and for the duration that the individual enrolled in the plan is under age 65.

(C) Notwithstanding subsections (c) or (d) of this section, an issuer may not apply a preexisting condition exclusion or a waiting period to a qualifying individual.

(5) An issuer filing for a rate increase applicable to a Medicare supplement policy on or before January 1, 2028, in which the rate increase relies on actual or expected experience resulting from the implementation of Insurance Code §1652.059 or §1652.060, concerning Enrollment Period for Certain Individuals Younger Than 65, must include in the filing a statement signed by an actuary as to whether the rates for those insureds under age 65 not qualifying under Insurance Code §1652.059 or §1652.060 satisfy the requirements of §3.3307 of this title (relating to Loss Ratio Standards and Refund or Credit of Premiums).

(c) If an applicant qualifies under subsection (a) of this section, is age 65 [~~years of age~~] or older, and submits an application during the period referenced in subsection (a) of this section and, as of the date of application, has had a continuous period of creditable coverage:

(1) [~~has had a continuous period of creditable coverage~~] of at least six months, the issuer may not exclude benefits based on a preexisting condition; or

(2) [~~has had a continuous period of creditable coverage~~] that is less than six months, the issuer must 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.

(d) Except as provided in subsection (c) of this section, §3.3312 of this title (relating to Guaranteed Issue for Eligible Persons; Notice Requirements), and §3.3306(b)(1)(A) of this title (relating to Minimum Benefit Standards), subsection (a) of this section may 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.

(e) The following examples illustrate the application of subsection (c)(1) and (2) of this section, as prescribed by the Secretary:

(1) Individual A--["] No preexisting condition exclusion period. Relevant creditable coverage history: Individual A had coverage under an individual policy for four months beginning on May 1, 1998, through August 31, 1998, followed by a gap in coverage of 61 days until October 31, 1998. Individual A had coverage under an individual health plan beginning on November 1, 1998, for three months through January 31, 1999, followed by a gap in coverage of 59 days or until March 31, 1999, on which date Individual A submitted an application for a Medicare supplement policy. Under this example, the Medicare supplement issuer may not apply a preexisting condition exclusion period because Individual A has seven months of creditable coverage without a gap in coverage greater than 63 days.

(2) Individual B--["] Subject to a three-month preexisting condition exclusion period. Relevant creditable coverage history: Individual B is covered under an individual health insurance policy for one month beginning May 1, 1998, through May 31, 1998, followed by a gap in coverage of 61 days from June 1, 1998, through July 31, 1998. On August 1, 1998, Individual B is covered under an association health plan for two months through September 30, 1998, followed by a gap in coverage of 31 days or until October 31, 1998, on which date Individual B submitted an application for Medicare supplement coverage. Individual B has three months of creditable coverage. Under this example, the issuer of a Medicare supplement policy must give Individual B a three-month credit against any preexisting condition exclusion period.

(3) Individual C--^[4] Subject to a six-month preexisting condition exclusion period. Relevant creditable coverage history: Individual C is covered under an individual health insurance policy for one month beginning May 1, 1998, through May 31, 1998, followed by a gap in coverage of 61 days from June 1, 1998, through July 31, 1998. On August 1, 1998, Individual C is covered under an association health plan for two months through September 30, 1998, followed by a gap in coverage of 64 days or until November 4, 1998, on which date Individual C submitted an application for Medicare supplement coverage. Individual C has a gap in coverage of greater than 63 days. As a result, under this example, the Medicare supplement issuer can fully apply the preexisting condition exclusion provision to Individual C.

(f) Invitation to contract advertisements, as defined in §21.113(b) of this title (relating to Rules Pertaining Specifically to Accident and Health Insurance Advertising and Health Maintenance Organization Advertising), must include the following statement: "Benefits and premiums under this policy may be suspended for up to 24 months if you become entitled to benefits under Medicaid. You must request that your policy be suspended within 90 days of becoming entitled to Medicaid. If you lose (are no longer entitled to) benefits from Medicaid, this policy can be reinstated if you request reinstatement within 90 days of the loss of such benefits and pay the required premium."

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

Issued in Austin, Texas, on April 30, 2026.

Signed by:
Jessica Barta
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Jessica Barta, General Counsel
Texas Department of Insurance