Medicare Supplement Policies for Certain Individuals Under Age 65: Scope and Application of § 38.2-3610 (HB 1640/SB 1409) Frequently Asked Questions

During its 2023 regular session, the General Assembly enacted HB 1640/SB 1409, which amends § 38.2-3610 of the Code of Virginia ("Code"), effective January 1, 2024. This section concerns Medicare supplement policies for individuals with a qualifying disability. The amendments to the section expand the definition of a qualifying disability, create a new open enrollment period, and place a limitation on premium rates that issuers may charge for such plans.

The following questions are addressed to clarify the State Corporation Commission, Bureau of Insurance's (Bureau's) interpretation and expectation for compliance with this law, effective January 1, 2024, and to address compliance concerns related to the law that is now in effect.

Question 1: Can an issuer only issue a plan other than Plan A to disabled individuals under 65?

Answer: Yes. Pursuant to § 38.2-3610 of the Code as currently in effect, issuers must offer at least one Medicare supplement policy to individuals under 65 and eligible for Medicare by reason of disability that they currently offer to individuals 65 years of age and older. 14 VAC 5-170-75 C, 14 VAC 5-170-85 B and 14 VAC 5-170-87 require issuers to make Plan A available to each prospective policyholder and certificateholder, as well as make available Plans D or G for persons new to Medicare on or after January 1, 2020, (Plans C or F for those eligible prior to 2020) if more than one plan is offered; however, these requirements when read in conjunction with the Code would act to place limits on the type of plan(s) issuers must offer to disabled individuals. Such limits do not appear to be contemplated by the Code.

Question 2: Can an issuer who issues Medicare supplement policies offer a Medicare supplement plan only to individuals under 65 and eligible for Medicare by reason of disability?

Answer: No. 14 VAC 5-170-130 C does allow an issuer to create, for each standard Medicare supplement plan, a separate form of a policy for individuals under 65 with a qualifying disability; however, 14 VAC 5-170-100 A requires an issuer to make available each of its currently available standard Medicare supplement plans to all applicants who are 65 years or older, enrolled under Medicare Part B, and qualify for open enrollment. As such, an issuer that offers Medicare supplement plans cannot offer a Medicare supplement plan only to individuals under 65 who are eligible for Medicare by reason of disability.

This interpretation aligns with § 38.2-3610 of the Code that requires an issuer to offer at least one of its issued policies to disabled individuals. Additionally, since the Code revision effective January 1, 2024, removes the ability for issuers to develop premium rates specific to disabled individuals and instead requires premiums for disabled individuals to not exceed premiums charged to an individual aged 65 for that same plan, it is evident that the intent of the amended

law was for the same plan to be made available to both disabled individuals under 65 and individuals 65 and above.

A policy form previously issued only to individuals aged 65 or older and enrolled in Medicare Part B may be amended to be offered to individuals under 65 and eligible for Medicare by reason of disability, and new rates filed for approval to include those individuals. Alternatively, a new policy form to be issued to individuals under 65 and eligible for Medicare by reason of disability may be filed for any standard Medicare supplement benefit plan currently issued by the carrier to individuals aged 65 or older and enrolled in Medicare Part B.

Question 3: How does § 38.2-3610 of the Code apply to policies or certificates issued on a group basis or through a group trust?

Answer: For Medicare supplement policies or certificates issued on a group basis or through a group trust, § 38.2-3610 of the Code requires the carrier to offer to the group at least one plan it currently offers that will cover any applicant who is an eligible member of the applicable group, under age 65, and who meets Medicare eligibility requirements.

Question 4: Does the open enrollment period beginning January 1, 2024, apply only to individuals under 65 with end stage renal disease?

Answer: Yes. The language contained in § 38.2-3610 B of the Code, effective January 1, 2024, establishes a new and separate six-month open enrollment period for individuals under 65 and eligible for Medicare with end stage renal disease. The enrollment period established for end stage renal disease does not impact the open enrollment period previously established on January 1, 2021, for individuals who qualify for disability as defined by 42 U.S.C. §426(b).

Question 5: Do the premium rates limitations in § 38.2-3610 D of the Code, effective January 1, 2024, apply to *all* individuals who are under 65 with a qualifying disability, or *only* to those individuals who are under 65 and become eligible for Medicare by reason of disability on or after the effective date of the amendments?

Answer: Beginning January 1, 2024, all applicable policies issued or renewed on or after January 1, 2024, must comply with these premium rate requirements. The premium rate limitations under § 38.2-3610 D of the Code apply to *all* individuals who are under 65 with a qualifying disability, as coverage is issued or renewed on and after January 1, 2024. After January 1, 2024, the issuer will have to adjust premium rates for disabled individuals under 65 as required when a policy comes up for renewal. The limitation will not apply *only* to those under age 65 who become eligible for Medicare by reason of end stage renal disease.

To further explain this interpretation, if subsection D were to exclude policy renewals, individuals under age 65 and eligible for Medicare by reason of disability already enrolled in a plan would pay a different premium rate than the same class of individuals who enroll in the same plan on or after January 1, 2024. This result is discriminatory and thus prohibited.

Question 6: Is there a filing deadline to submit compliant forms and rates for the required January 1, 2024, effective date?

Answer: Yes, September 1, 2023, is the filing deadline.

Question 7: Can an issuer streamline their filing for a quicker review?

Answer: Yes.

1. File prior to the September 1 deadline. It is also recommended that any annual filing submitted before the deadline also include rates for the January 1, 2024, effective date.
2. Issuers that extend the current age 65 rate to disabled individuals under age 65 without further changes may have a shorter review time. Filings requiring unexpected corrections will experience longer review times.

Question 8: Does an issuer have to change their anniversary date to January 1 of each year?

Answer: No, it is suggested that issuers retain their current anniversary date.

Question 9: How soon can an issuer request a change to rates after January 1, 2024?

Answer: Issuers will not be able to revise their rates prior to April 2024, unless approved on a case-by-case basis due to special circumstances. It is recommended that changes planned for a first quarter anniversary be considered in the filing request for the January 1, 2024, effective date.

Question 10: May an issuer revise an approved application or enrollment form (application) to include a question to determine eligibility for the 6-month enrollment period for individuals under 65 that are eligible for Medicare by reason of disability under 42 U.S.C. § 426-1 beginning on January 1, 2024?

Answer: Yes. 14 VAC 5-170-160 A requires certain questions to be included in Medicare Supplement applications. These questions should be sufficient after June 30, 2024, to determine eligibility for coverage for those individuals under 65 who are either eligible for Medicare due to disability under 42 U.S.C. § 426(b), or eligible for Medicare coverage due to disability under 42 U.S.C. § 426-1 (End Stage Renal Disease) (ESRD). However, an additional question may be necessary to trigger the open enrollment period for individuals eligible for Medicare due to ESRD, as required by § 38.2-3610 B of the Code of Virginia.

On a temporary basis, we are allowing carriers the opportunity to update a currently approved Medicare supplement application form to add the question italicized below verbatim to Question 2:

2 a. Are you younger than age 65 and eligible for Medicare by reason of disability as defined by federal law?

Yes____ No____

b. Are you eligible for Medicare under 42 USC §426-1 (end state renal disease)?

Yes____ No____

c. Are your enrolled or expect to be enrolled in Medicare Part A or Part B?

Yes____ No____

d. If yes, what is the effective date of Part A_____; Part B_____?

This question may remain in the approved application form only until 6/30/2024. As of 7/1/2024, the temporary question must be removed. We request that carriers submit the revised form with the rate filing under Supporting Documentation, using the existing, approved form number. A red lined version of the revised application should be provided.

We ask that the filings include a note certifying that:

1. This question will appear in the application only until 6/30/2024.
2. No other changes have been made to the previously approved application form.

If the revised application form submission duplicates the above language and is accompanied by the above certifications, the form will be received and acknowledged.

Should a carrier choose to submit a new application or amendment form, those forms should be submitted under the Form Schedule. Such forms will be subject to a complete review for approval.

Questions should be sent to Greg Smith, greg.smith@scc.virginia.gov.