State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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TO: Legislative Reference Bureau
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FROM: Richard Wicka, Chief Legal Counsel RBW
Office of the Commissioner of Insurance

DATE: August 12, 2019

SUBJECT: Section Ins 3.39 and 3.55, Wis. Adm. Code, relating to Medicare supplement insurance and affecting small business.
Clearinghouse Rule No. 19-036

This rule is in final draft form and has been submitted to the chief clerk of each house of the legislature. Please publish a statement to this effect in the Wisconsin Administrative Register, pursuant to Wis. Stat. § 227.19 (2). We have e-mailed you an electronic copy of the text of the rule.

For additional information or if you do not receive the e-mail, please contact Karyn Culver at (608) 267-9586 or karyn.culver@wisconsin.gov.

ORDER REPEALING, RENUMBERING, RENUMBERING AND AMENDING, AMENDING, REPEALING AND RECREATING AND CREATING A RULE

Office of the Commissioner of Insurance

Rule No. Agency 145 – INS 3.39 and 3.55, Wis. Adm. Code, proposes an order to **repeal** INS 3.39 (1) (c), (2) (a) 4., (c) 1. and (d) 4., (3) (r) 1. to 3., (4) (a) 18r. (intro.), (4s) (a) 21. (intro.), (15) (Note), (30) (b), (30m) (b), (31) (bm), Appendices 8 and 9; **to renumber and amend** INS 3.39 (3) (r) (intro.), (4) (a) 18r. a. to c., (4m), (4s) (intro.), (a) (intro.) and 1. to 20., 21. a. to c., 22., and (b) to (f), (5m) (a) 1., (b) and (c), (14m) (d) (intro.) and 1. to 3., (16) (d) 3., (34) (ez), Appendix 2 to Appendix 5, INS 3.55 (d) and (e); **to consolidate, renumber and amend** INS 3.39 (2) (c) (intro.) and 2.; **to amend** INS 3.13 (2) (j) (intro.), 3. and (Note), INS 3.29 (3) (a) and (7) (b), INS 3.39 (1) (a), (b), and (d), (2) (a) (intro.) 1. to 3., 5., and (b), (d) (intro.), (e) (intro.) and 1., (3) (c) (intro.) and 1., (ce), (e) to (g), (i) 1. c., d. and 5. a., (v), (w), (y), (za) and (zb), (4) (title), (intro.), (a) (intro.) 1. to 7., 9. to 12., and 16., 18. and 18p., (b) (intro.) and 1. to 7., (c), (e), and (g), (5) (title), (intro.), (c) (intro.), (n) 12., (o) 12., (5m) (title), (a) 2. (intro.), (e), (g) 12., (h) 12., and (k) 4., (6) (intro.), (7) (title), (a) (intro.), (b) (intro.), 1. (intro.), c. and 2., (c), (cm) and (dm), (8) (title), (a) (intro.), (c), and (e), (10) (title), (a) and (d) 1., (13), (14) (a), (c) (intro.) 1. to 6., (d), (i) and (L), (14m) (title), (a), (c) 1. to 6., and (i) (intro.), (15), (16) (a), (c), (d) (intro.), 1., and (e), (17), (21) (a), (22) (d), (f) (intro.), and 1., (23) (a) (intro.), (c) and (e), (24) (a) (intro.) and 3., (25) (a) to (c); (26) (a) (intro.),1., and (b), (27), (28) (title), (a) (intro.), (b) 2. and (c), (29) (a) and (b) 1., (30) (a), (k) (intro.), (n) (intro.), (q) 12. and (r) 12., (30m) (a) 1., (i) 1. (intro.) and 8., (k) (intro.), (n) (intro.), (q) (intro.), (r) 12, (s) 12., (34) (a) 1., 2., (b) (intro.), 1s. and 2., (e) 4. and 5., (f) 1. and 2., (35) (intro.) and (a), Appendix 1, Appendix 6 and 7, INS 3.55 (title) (1), (2), (4) (a) and (5) (intro.), INS 9.01 (3m); **to repeal and recreate** INS 3.39 (31) (a) and (b); **to create** INS 3.39 (3) (fm), (gm), (jm), (pm), (um), (ve), (vm), (vs), (we), (wm), (ws), (zag), (zar), (zbm), and (zcm), (3g), (4t), (5m) (a) (intro.), (a) 1. b., (5t), (7) (ct) and (dt), (14t), (16) (d) 3. a. to g., (21) (f), (24) (a) 4., (26) (a) 3. to 6., (30t), (34) (et), Appendices 2t, 3t, 4t, 5t, 6m, and 6t, Wis. Adm. Code, relating to Medicare supplement insurance and affecting small business.

The statement of scope for this rule SS: 084-18, was approved by the Governor on July 19, 2018, published in Register No. 751B, on July 30, 2018, and was approved by the Commissioner on August 28, 2018. The proposed rule was approved by the Governor on August 9, 2019, to submit to the legislature and was submitted to the legislature on August 12, 2019.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. Statutes interpreted:

ss. 185.983 (1m), 600.03, 601.01 (2), 609.01 (1g) (b), 625.16, 628.34 (12), 628.38, 631.20 (2), 632.73 (2m), 632.76 (2) (b) and 632.81, 632.84, 632.895 (2), (3), (4), and (6), Wis. Stats.

2. Statutory authority:

ss. 601.41 (3), 625.16, 628.34 (12), 628.38, 632.73 (2m) and (3) (b), 632.76 (2) (b), 632.81, Wis. Stats.

3. Explanation of OCI's authority to promulgate the proposed rule under these statutes:

The statutes all relate to the commissioner's authority to promulgate rules regulating the business of insurance as it relates to Medicare supplement and Medicare replacement insurance products. Specifically, ss. 601.41 (3), 625.16, 628.38, 632.73 (2m) and (3) (b), 632.76 (2) (b), and 632.81, Wis. Stats., permit the commissioner to promulgate rules regulating various aspects of Medicare supplement and Medicare replacement products while ss. 628.34, and 628.38, Wis. Stats., authorize the commissioner to promulgate rules governing disclosure requirements and unfair marketing practices for disability policies that includes Medicare supplement and Medicare replacement products.

4. Related statutes or rules:

The Centers for Medicare & Medicaid Services (CMS) required the National Association of Insurance Commissioners, (NAIC) to make conforming changes to the Medicare supplement model regulation by incorporating changes to implement the federal Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), P.L. 114-10. States are required to adopt the NAIC model revision in order to continue regulating the Medicare supplement marketplace.

CMS delegates enforcement of MACRA to the states that have incorporated the NAIC model into states insurance laws or regulations. To date Wisconsin has passed NAIC model regulations through statutes and regulations governing Medicare supplement and Medicare replacement products. In Wisconsin Medicare supplement and Medicare replacement products are currently regulated under s. Ins 3.39, Wis. Adm. Code, inclusive of the appendices that this proposed rule modifies to implement MACRA requirements.

5. The plain language analysis and summary of the proposed rule:

The proposed rule amends the current rules to incorporate the NAIC model regulation that implements the Medicare Supplement Insurance Minimum Standards Model Act to comply with MACRA. Medicare supplement policies are policies purchased by Medicare beneficiaries to cover

Medicare deductibles, co-insurance and selected services that Medicare does not cover. Medicare establishes eligibility rules, benefits and coverage limits.

The proposed rule implements changes to the Medicare supplement benefits that are permitted to be offered to persons newly eligible for Medicare on or after January 1, 2020. Wisconsin is a waived state, meaning Wisconsin is waived from implementing the standardized Medicare supplement Plans A to N, and instead requires minimum standardized supplemental benefits with seven standardized benefit riders. This is advantageous to both the insurer and the consumers as this system permits consumers to compare products on an equal basis to determine the best product to meet their insurance needs. However, beginning with January 1, 2020, consumers who are first eligible for Medicare on or after January 1, 2020, may not be offered the Medicare Part B deductible in accordance with MACRA. This change does not affect those who became eligible for Medicare prior to January 1, 2020, through age or disability, including end-stage renal disease. This change also does not limit the ability for insurers to continue to market and offer the Medicare Part B deductible to consumers first eligible for Medicare prior to January 1, 2020.

The remainder of the proposed rule; updates terminology, creates consistency in numbering and references, and updates and simplifies the appendices to the rule. However, since Medicare supplement and Medicare select plans are guaranteed renewable for life, OCI cannot repeal original or previous federal law changes reflected in the current regulation as individuals may still have existing policies regulated under those sections. Instead OCI, in this draft, adopts a parallel citation approach for ease of navigation. Subsections that apply to all plans or a plan issued to groups or individuals who were first eligible for Medicare prior to June 1, 2010, appear with just a number for the subsection, i.e. s. Ins 3.39 (4), Wis. Adm. Code. All appendices and subsections that apply to policies issued to groups or individuals who were first eligible for Medicare on or after June 1, 2010, and prior to January 1, 2020, appear as a number with the

letter "m" following the subsection number, i.e. s. Ins 3.39 (4m), Wis. Adm. Code. For the new plans that will be issued to groups or individuals who are newly eligible for Medicare on or after January 1, 2020, all appendices and subsections appear as a number with the letter "t" following the subsection number, i.e. s. Ins 3.39 (4t), Wis. Adm. Code. Finally, there are citation corrections within cross references to existing or newly created s. Ins 3.39, Wis. Adm. Code, provisions within the insurance administrative code.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

This proposed rule will permit Wisconsin to continue to have jurisdiction and control over Medicare supplement, select and cost products offered in this state. Wisconsin is a waived state so Wisconsin consumers are not subjected to the federal plan listings typically associated with Medicare supplemental plans that are enumerated by letters that frequently change. Further, Wisconsin developed a standardized set of basic coverage inclusive of applicable mandates and a finite number of riders prior to 1990. This approach allows consumers to easily compare "apple to apple" coverage and options available for their supplemental needs.

7. Summary of any public comments and feedback on the statement of scope of the proposed rule that the agency received at any preliminary public hearing and comment period held under s. 227.136, Stat., and a description of how and to what extent the agency took those comments and that feedback into account in drafting the proposed rule.

The office gave notice of a preliminary public hearing on a statement of scope for s. Ins 3.39 and 3.55, Wis. Adm. Code, relating to amending Medicare supplemental insurance and reporting requirements. The notice was published in the Wisconsin Administrative Register on July 30, 2018, in Register No. 751B. A public hearing was held on August 9, 2018 at 11:00 am. Notice as also published on the office's website. The public could provide oral or written testimony and a public comment period was open until 4:00 pm on August 20, 2018.

Testimony was received by OCI that addressed areas of potential confusion between the NAIC model and the federal MACRA law. Specifically, testimony highlighted that the key decision point for what coverage a person who is Medicare eligible may receive through a Medicare supplemental product is tied to the date the individual first became eligible for Medicare. The testimony provided highlighted that although MACRA required insurers to not offer the Medicare Part B medical deductible rider to persons first eligible for Medicare on or after January 1, 2020, insurers could continue offering the rider to persons eligible for Medicare prior to January 1, 2020. Additionally, it was noted that given Medicare supplemental products are guaranteed renewable for life thus necessitating insurers to continue to renew the Medicare Part B medical deductible rider coverage. The office, in drafting the permanent rule, incorporated the suggestions raised in oral testimony into the drafted rule.

8. Comparison of similar rules in adjacent states as found by OCI:

Illinois: 50 Ill. Adm. Code 2008, Minimum Standards for Individual and Group Medicare Supplement Insurance. Effective November 26, 2018. Please note that as Wisconsin is a waived state for Medicare supplemental insurance there are no similar rules in adjacent states.

Iowa: IA ADC 191-37 (514D). Effective May 15, 2019 implementing MACRA. Please note that as Wisconsin is a waived state for Medicare supplemental insurance there are no similar rules in adjacent states.

Michigan: M.C.L.A 500.3801-3861. Effective March 20, 2019. Please note that as Wisconsin is a waived state for Medicare supplemental insurance there are no similar rules in adjacent states.

Minnesota: Minnesota Statutes s. 62A.3099 to 62A.44 are being revised by 2019 Legislative Bill HF2051 and SF2313. The proposed bills will implement the MACRA changes. Please note that as Wisconsin is a waived state for Medicare supplemental insurance there are no similar rules in adjacent states.

9. A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:

OCI's review of complaints, NAIC models, insurer's financial information, and CMS data indicates that Medicare currently covers 60 million Americans, 1,143,459 of whom are Wisconsin residents as of 2018. An estimated 25 percent of Wisconsin Medicare beneficiaries are covered

by Medicare supplement policies. Nationally, the per person personal health care spending for the 65 and older population was $18,988 in 2012.

Information collected by the OCI indicates that 48 insurance companies offer Medicare supplement, Medicare cost or Medicare select policies to Wisconsin consumers eligible for Medicare due to age or disability. In addition, there are 34 insurance companies that have Medicare supplement policyholders although the companies no longer actively market Medicare supplement coverage in Wisconsin. At year-end 2017, there were 289,662 Wisconsin Medicare beneficiaries with Medicare supplement policies.

10. Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:

OCI reviewed financial statements and other reports filed by life, accident and health insurers and determined that none qualify as a small business. Wisconsin currently has 48 insurance companies actively marketing offering Medicare supplement, Medicare cost and Medicare select insurance policies and an additional 34 companies supporting guaranteed renewable policies although no longer actively marketing Medicare supplement policies.

11. See the attached Private Sector Fiscal Analysis.

The proposed rule will not significantly impact the private sector. Insurers offering Medicare supplement policies (Medicare supplement, Medicare cost, and Medicare select policies) may incur costs associated with developing new Medicare supplement policies and marketing materials, mailing riders and explanatory materials to existing policyholders. However, these costs are offset by the insurers' ability to continue offering Medicare supplement policies to Wisconsin consumers. Further, removing the Medicare Part B medical deductible rider as an optional purchase to persons first eligible for Medicare on or after January 1, 2020, will not adversely impact consumers, agents or insurers as the typical premium for rider closely approximates the actual deductible amount that for 2019 will be $185.00.

12. A description of the Effect on Small Business:

The proposed rule will not significantly impact the private sector. Insurers offering Medicare supplement policies (Medicare supplement, Medicare cost, and Medicare select policies) may incur costs associated with developing new Medicare supplement policies and marketing materials, mailing riders and explanatory materials to existing policyholders. However, these costs are offset by the insurers' ability to continue offering Medicare supplement policies to Wisconsin consumers. Further, removing the Medicare Part B medical deductible rider as an optional purchase for newly eligible persons on or after January 1, 2020, will not adversely impact consumers, agents, or insurers as the typical premium for Medicare Part B medical deductible riders closely approximated the actual deductible amount that for 2019 will be $185.00.

13. Agency contact person:

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the web site under Rule-Making Information at:

https://oci.wi.gov/Pages/RegulationHome.aspx

or by contacting Karyn Culver, Paralegal, at:

Phone: (608) 267-9586
Email: karyn.culver@wisconsin.gov
Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

14. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on May 21, 2019.

Mailing address:

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The proposed rule changes are:

SECTION 1. INS 3.13 (2) (j) (intro.), 3. and (Note) are amended to read:

INS 3.13 (2) (j) Except as provided in s. Ins 3.39 (7) (d), (dm), and (dt), the provision or notice regarding the right to return the policy required by s. 632.73, Stats., shall comply with all of the following:

3. Provide an unrestricted right to return the policy, within 10 days from the date it is received by the policyholder, to the issuer at its home or branch office, if any, or to the agent through whom it was purchased; except it shall provide an unrestricted right to return the policy within 30 days of the date it is received by the policyholder in the case of a Medicare supplement policy subject to s. Ins 3.39 (4), ~~(4s)~~ (4m), (4t), (5), (5m), (5t), and (6), issued pursuant to a direct response solicitation. Provision shall not be made to require the policyholder to set out in writing the reasons for returning the policy, to require the policyholder to first consult with an agent of the issuer regarding the policy, or to limit the reasons for return.

Note: Paragraph (j) was adopted to assist in the application of s. 204.31 (2) (a), Stats., to the review of accident and sickness policy and other contract forms. Those statutory requirements are presently included in s. 632.73, Stats. The original statute required that the provision of notice regarding the right to return the policy must be appropriately captioned or titled. Since the important rights given the insured are to examine the policy and to return the policy, the rule requires that the caption or title must refer to at least one of these rights—examine or return. Without such reference, the caption or title is not considered appropriate.

The original statute permitted the insured to return the policy for refund to the home office or branch office of the insurer or to the agency with whom it was purchased. In order to assure the refund is made promptly, some insurers prefer to instruct the insured to return the policy to a

particular office or agent for a refund. Notices or provisions with such requirements will be approved on the basis that the insurer must recognize an insured's right to receive a full refund if the policy is returned to any other office or agent mentioned in the statute.

Also, the statute permits the insured to return a policy for refund within 10 days from the date of receipt. Some insurers' notices or provisions regarding such right, however, refer to delivery to the insured instead of receipt by the insured or do not specifically provide for the running of the 10 days from the date the insured receives the policy. Notices or provisions containing such wording will be approved on the basis that the insurer will not refuse refund if the insured returns the policy within 10 days from the date of receipt of the policy.

Sections 632.73 (2m) and 600.03 (35) (e), as created by Chapter 82, Laws of 1981, provide for the right of return provisions in certain certificates of group Medicare supplement policies. Therefore, for purposes of this subparagraph, the word policy includes a Medicare supplement certificate subject to s. Ins 3.39 (4), ~~(4s)~~ (4m), (4t), (5), (5m), (5t), and (6).

SECTION 2. INS 3.29 (3) (a) and (7) (b) are amended to read:

INS 3.29 (3) (a) Group, blanket or group type, except Medicare supplement and ~~replacement~~ Medicare cost insurance policies subject to s. Ins 3.39 (4), ~~(4s)~~ (4m), (4t), (5), (5m), (5t), and (7).

(7) (b) The notice required by sub. (6) for a Medicare supplement policy subject to s. Ins 3.39 (4), ~~(4s)~~ (4m), (4t), (5), (5m), (5t), and (7), shall include an introductory statement in substantially the following form: Your new policy provides _____ days within which you may decide without cost whether you desire to keep the policy.

SECTION 3. INS 3.39 (1) (a) and (b) are amended to read:

INS 3.39 (1) (a) This section establishes requirements for health and other disability insurance policies primarily sold to Medicare eligible persons. Disclosure provisions are required for other disability policies sold to Medicare eligible person because such policies frequently are

represented to, and purchased by, the Medicare eligible as supplements to Medicare products ~~including Medicare Advantage and Medicare Prescription Drug plans~~.

(b) This section seeks to reduce abuses and confusion associated with the sale of disability insurance to Medicare eligible persons by providing ~~for~~ reasonable standards. The disclosure requirements and established benefit standards are intended to provide to Medicare eligible persons guidelines that they can use to compare disability insurance policies and certificates as described in s. Ins 6.75 (1) (c), and to aid them in the purchase of policies and certificates intended to supplement Medicare ~~and Medicare Advantage plans~~ policies that are suitable for their needs. This section is designed not only to improve the ability of the Medicare eligible consumer to make an informed choice when purchasing disability insurance, but also to assure the Medicare eligible persons of this state that the commissioner will not approve a policy or certificate as "Medicare supplement" or as ~~a~~ "Medicare ~~replacement~~ cost" unless it meets the requirements of this section.

SECTION 4. INS 3.39 (1) (c) is repealed.

SECTION 5. INS 3.39 (1) (d) is amended to read:

INS 3.39 (1) (d) Wisconsin statutes interpreted and implemented by this rule are ss. 185.983 (1m), 600.03, 601.01 (2), 601.42, 609.01 (1g) (b), 625.16, 628.34 (12), 628.38, 631.20 (2), 632.73 (2m), 632.76 (2) (b), 632.81, 632.895 (2), (3), (4) and (6) ~~and (9)~~, Stats.

SECTION 6. INS 3.39 (2) (a) (intro.), 1. and 3. are amended to read:

INS 3.39 (2) (a) Except as provided in pars. (d) and (e), this section applies to any group or individual Medicare supplement policy or certificate, or Medicare select policy or certificate as ~~defined~~ described in s. 600.03 (28r), Stats., or any Medicare ~~replacement~~ cost policy as ~~defined~~ described in s. 600.03 (28p) (a) and (c), Stats., including all of the following:

1. Any Medicare supplement policy, Medicare select policy, or Medicare ~~replacement~~ cost policy issued by a voluntary sickness care plan subject to ch. 185, Stats.~~;~~

2. Any certificate issued under a group Medicare supplement policy or group Medicare ~~replacement~~ select policy~~;~~.

3. Any individual or group policy sold in Wisconsin predominantly to individuals or groups of individuals who are 65 years of age or older ~~which~~ that offers hospital, medical, surgical, or other disability coverage, except for a policy ~~which~~ that offers solely nursing home, hospital confinement indemnity, or specified disease coverage~~; and~~.

SECTION 7. INS 3.39 (2) (a) 4. is repealed.

SECTION 8. INS 3.39 (2) (a) 5. and (b) are amended to read:

INS 3.39 (2) (a) 5. Any individual or group policy or certificate sold in Wisconsin to persons under 65 years of age and eligible for ~~medicare~~ Medicare by reason of disability ~~which~~ that offers hospital, medical, surgical or other disability coverage, except for a policy or certificate ~~which~~ that offers solely nursing home, hospital confinement indemnity or specified disease coverage.

(b) Except as provided in pars. (d) and (e), subs. (9) and (11) apply to any individual disability policy sold to a person eligible for Medicare ~~which~~ that is not a Medicare supplement, Medicare select, or a Medicare ~~replacement~~ cost policy as described in par. (a).

SECTION 9. INS 3.39 (2) (c) (intro.) and 2. are consolidated and renumbered INS 3.39 (2) (c) and, as renumbered, are amended to read:

INS 3.39 (2) (c) Except as provided in par. (e), sub. (10) applies to~~:~~

~~2. Any~~ any individual or group hospital or medical policy ~~which~~ that continues with changed benefits after the insured becomes eligible for Medicare.

SECTION 10. INS 3.39 (2) (c) 1. is repealed.

SECTION 11. INS 3.39 (2) (d) (intro.) is amended to read:

INS 3.39 (2) (d) Except as provided in subs. (10) and (13), this section does not apply to any of the following:

SECTION 12. INS 3.39 (2) (d) 4. is repealed.

SECTION 13. INS 3.39 (2) (e) (intro.) and 1. are amended to read:

INS 3.39 (2) (e) This section does not apply to either of the following:

1. A policy providing solely accident, dental, vision, disability income, or credit disability income coverage~~; or~~.

SECTION 14. INS 3.39 (3) (c) (intro.) and 1., (ce), (e) and (f) are amended to read:

INS 3.39 (3) (c) "Applicant" means either of the following:

1. In the case of an individual Medicare supplement, Medicare select, or Medicare ~~replacement~~ cost policy, the person who seeks to contract for insurance benefits.

(ce) "Balance bill" means seeking: to bill, charge, or collect a deposit, remuneration or compensation from; to file or threaten to file with a credit reporting agency; or to have any recourse against an ~~enrollee~~ insured or any person acting on the ~~enrollee's~~ insured's behalf for health care costs for which the ~~enrollee~~ insured is not liable. The prohibition on recovery does not affect the liability of an ~~enrollee~~ insured for any deductibles, coinsurance or copayments, or for premiums owed under the policy or certificate.

(e) "CMS" means the Centers for Medicare & Medicaid Services within the U.S. department of health and human services.

(f) "Certificate" means, ~~any~~ in this section, a certificate delivered or issued for delivery in this state under a ~~group~~ Medicare supplement policy or under a Medicare select policy that is issued on a group basis, i.e. employer retiree group.

SECTION 15. INS 3.39 (3) (fm) is created to read:

INS 3.39 (3) (fm) "Certificateholder" means an individual member of a group that is receives a certificate that identifies the individual as a participant in the group Medicare supplement policy or the group Medicare select policy issued in this state.

SECTION 16. INS 3.39 (3) (g) is amended to read:

INS 3.39 (g) "Certificate form" means, in this section, the form on which the certificate is delivered or issued for delivery by the issuer to a group that receives insurance coverage through a group Medicare supplement policy, or a group Medicare select policy.

SECTION 17. INS 3.39 (3) (gm) is created to read:

INS 3.39 (3) (gm) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare select issuer or its network providers.

SECTION 18. INS 3.39 (3) (i) 1. c. and d., and 5. a. are amended to read:

INS 3.39 (3) (i) 1. c. Part A or Part B of Title XVIII of the ~~Social Security Act~~ social security act (Medicare);

d. Title XIX of the ~~Social Security Act~~ social security act (Medicaid), other than coverage consisting solely of benefits under section 1928;

5. a. Medicare supplemental health insurance as defined under section 1882 (g) (1) of the ~~Social Security Act~~ social security act;

SECTION 19. INS 3.39 (3) (jm), and (pm) are created to read:

INS 3.39 (3) (jm) "Grievance" means dissatisfaction with the administration, claims practices or provision of services concerning a Medicare select issuer or its network providers that is expressed in writing by a policyholder or certificateholder under a Medicare select policy or certificate.

(pm) "MACRA" means the Medicare Access and CHIP Reauthorization Act of 2015, PL 114-10, signed April 16, 2015.

SECTION 20. INS 3.39 (3) (r) (intro.) is renumbered INS 3.39 (3) (r) and amended to read:

INS 3.39 (3) (r) "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 USC 1395w-28 (b) (1), as amended~~, and includes any of the following:~~.

SECTION 21. INS 3.39 (3) (r) 1. to 3. are repealed.

SECTION 22. INS 3.39 (3) (um) is created to read:

INS 3.39 (3) (um) "Medicare cost policy" means a Medicare replacement policy that is offered by an issuer that has a contract with CMS to provide coverage when services are provided within the issuer's geographic service area and through network medical providers selected by the issuer. A "Medicare cost policy" is issued to an individual who is the policyholder.

SECTION 23. INS 3.39 (3) (v) is amended to read:

INS 3.39 (3) (v) "Medicare replacement ~~coverage~~ policy" or "Medicare replacement insurance policy" means ~~coverage~~ a policy that ~~meets the definition~~ is described in s. 600.03 (28p) (a) or (c), Stats., as interpreted by sub. (2) (a), and that provides coverage that conforms to subs. (4), (4m), ~~(4s)~~ (4t), and (7). "Medicare replacement ~~coverage~~ policy" includes Medicare cost ~~and Medicare Advantage plans~~ policies.

SECTION 24. INS 3.39 (3) (ve), (vm), and (vs) are created to read:

INS 3.39 (3) (ve) "Medicare select certificate" means a policy that is issued to a group that provides Medicare supplement coverage to the group's members when services are obtained through network medical providers selected by the issuer. Individuals that receive coverage through the group Medicare select policy receive a Medicare select certificate that demonstrates participation in the group coverage.

(vm) "Medicare select policy" means a policy that is issued to an individual or policyholder that provides Medicare supplement coverage when services are obtained by the policyholder through a network of medical providers selected by the issuer.

(vs) "Medicare supplement certificate" means a policy that is issued to a group that provides Medicare supplement coverage to the group's members. Individuals that receive

coverage through the group Medicare supplement policy receive a Medicare supplement certificate that demonstrates participation in the group coverage.

SECTION 25. INS 3.39 (3) (w) is amended to read:

INS 3.39 (3) (w) "Medicare supplement coverage" or "Medicare supplement insurance" means coverage that meets the definition in s. 600.03 (28r), Stats., as interpreted by sub. (2) (a), and that conforms to subs. (4), (4m), ~~(4s)~~(4t), (5), (5m), (5t), (6), (30), ~~and~~ (30m), and (30t). "Medicare supplement coverage" is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expense of persons eligible for Medicare. "Medicare supplement coverage" includes group and individual Medicare supplement and group and individual Medicare select ~~plans~~ policies and certificates but does not include coverage under Medicare Advantage plans established under Medicare Part C or Outpatient Prescription Drug plans established under Medicare Part D.

SECTION 26. INS 3.39 (3) (we), (wm), and (ws) are created to read:

INS 3.39 (3) (we) "Medicare supplement policy" means a policy that is issued to an individual or policyholder that provides Medicare supplement coverage.

(wm) "Network provider," means a provider of health care, or a group of providers of health care, ~~which has~~ that have entered into a written agreement with the issuer to provide health care benefits to an insured under a Medicare select policy or Medicare select certificate.

(ws) "Newly eligible" means a person who meets one of the following criteria:

1. The person has attained age 65 on or after January 1, 2020.

2. The person, by reason of entitlement to benefits under Medicare Part A pursuant to section 226 (b) or 226A of the social security act, or who is deemed to be eligible for benefits under section 226 (a) of the social security act on or after January 1, 2020.

SECTION 27. INS 3.39 (3) (y) and (za) are amended to read:

INS 3.39 (3) (y) "Outline of coverage" means a printed statement as defined by s. Ins 3.27 (5) (L), ~~which~~ that meets the requirements of ~~sub.~~ subs. (4) (b), (4m) (b), or (4t) (b), as applicable.

(za) "PACE" means Program of All–Inclusive Care for the Elderly (PACE) under section 1894 of the ~~Social Security Act~~ social security act 42 USC 1302 and 1395.

SECTION 28. INS 3.39 (3) (zag) and (zar) are created to read:

INS 3.39 (3) (zag) "Policyholder" has the meaning provided at s. 600.03 (37), Stat.

(zar) "Policy or certificate forms of the same type" means, for purposes of calculating loss ratios, rates, refunds or premium credits, each type of form filed with the commissioner including; individual Medicare supplement policy forms, individual Medicare select policy forms, individual Medicare cost policy forms, group Medicare select certificate forms, and group Medicare supplement certificate forms.

SECTION 29. INS 3.39 (3) (zb) is amended to read:

INS 3.39 (3) (zb) "Replacement" means any transaction, other than when used to refer to an authorized Medicare Advantage policy, ~~wherein~~ where new individual or group Medicare supplement or individual Medicare cost insurance is to be purchased, and it is known to the agent or issuer at the time of application that, as part of the transaction, existing accident and sickness insurance has been or is to be lapsed, cancelled or terminated or the benefits ~~thereof~~ are substantially reduced. "Replacement" includes transactions replacing a Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy within the same insurer or affiliates of the insurer.

SECTION 30. INS 3.39 (3) (zbm), (zcm) and (3g) are created to read:

INS 3.39 (3) (zbm) "Restricted network provision," means any provision that conditions the payment of benefits, in whole or in part, on the use of network providers.

(zcm) "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare select policy or certificate.

(3g) MEDICARE ELIGIBLE PERSON. **(a)** Generally, an individual who attains age 65 or older, an individual under the age of 65 with certain disabilities, or an individual with end-stage renal disease is eligible to enroll in Medicare. The date a person is first eligible for Medicare Part B or

first elected Medicare Part A establishes the benefits available regardless of the date of election provided the benefit is offered in the market. In addition to the provisions that apply to all Medicare supplement and Medicare cost policies, the following identify the benefits and coverage subsections that have provisions tied to the date and year when a person is first eligible for Medicare Parts A and B:

1. For persons first eligible for Medicare Part A and B before June 1, 2010, subs. (4), (5), (7) (a), and (30) describe benefits and coverage available as contained in Appendix 1, and are applicable in addition to any provision in this section that generally pertains to Medicare eligible persons.

2. For persons first eligible for Medicare Part A and B on or after June 1, 2010, and prior to January 1, 2020, subs. (4m), (5m), (7) (dm), (14m), and (30m) describe benefits and coverage available as contained in Appendices 2m, 3m, 4m, 5m and 6m and are applicable in addition to any provision in this section that generally pertains to Medicare eligible persons.

3. For persons first eligible for Medicare Part A and B on or after January 1, 2020, MACRA designated Medicare eligible persons as "newly eligible" to distinguish them from a person eligible prior to January 1, 2020. For these newly eligible persons, subs. (4t), (5t), (7) (dt), (14t), and (30t) describe benefits and coverage available as contained in Appendices 2t, 3t, 4t, 5t, and 6t and are applicable in addition to any provision in this section that generally pertains to Medicare eligible persons.

(b) Medicare supplement policies and certificates and Medicare select policies and certificates are guaranteed renewable for life. Therefore, a Medicare eligible person can, at his or her choice, elect to receive benefits and coverage under a policy that may have fewer riders available. An insurer may not require the Medicare eligible person to replace existing coverage with coverage reflecting recent changes, including changes due to MACRA. This means insurers may no longer actively market the Medicare Part B medical deductible rider to persons who are newly eligible for Medicare on or after January 1, 2020. A Medicare eligible person who is first

eligible for Medicare prior to January 1, 2020, may elect the Medicare Part B medical deductible rider coverage at any time, provided an insurer is offering that coverage. If an insured was eligible for Medicare prior to January 1, 2020 and elected the Medicare Part B medical deductible rider coverage, upon renewal of the policy or certificate that person shall be eligible to continue to receive benefits provided by the Medicare Part B medical deductible rider in accordance with the terms of the Medicare supplement policy or certificate or Medicare select policy or certificate.

SECTION 31. INS 3.39 (4) (title), (intro.), (a) (intro.), 1. to 7., 9. to 12., 16., 18., and 18p. are amended to read:

INS 3.39 (4) MEDICARE SUPPLEMENT POLICY AND CERTIFICATE, MEDICARE SELECT POLICY AND CERTIFICATE AND MEDICARE ~~REPLACEMENT~~ COST POLICY ~~AND CERTIFICATE~~ REQUIREMENTS FOR POLICIES AND CERTIFICATES OFFERED TO PERSONS FIRST ELIGIBLE FOR MEDICARE PRIOR TO JUNE 1, 2010. Except as explicitly allowed by subs. (5), (7), and (30), no disability insurance policy or certificate shall relate its coverage to Medicare or be structured, advertised, solicited, delivered or issued for delivery in this state after December 31, 1990, for policies or certificates issued to persons who were first eligible for Medicare ~~with effective dates~~ prior to June 1, 2010, as a Medicare supplement policy or certificate, as a Medicare select policy or certificate, or as a Medicare ~~replacement~~ cost policy ~~or certificate, as defined in s. 600.03 (28p) (a) and (c), Stats.,~~ unless ~~it~~ the policy or certificate complies, as applicable, with all of the following :

(a) The Medicare supplement policy and certificate, Medicare select policy or certificate, or the Medicare cost policy complies, as applicable, with all the following requirements:

1. Provides only the coverage set out in sub. (5), (7), or (30) and applicable statutes and contains no exclusions or limitations other than those permitted by sub. (8). No issuer may issue a Medicare cost policy, Medicare supplement policy or certificate, or Medicare select policy or certificate without prior approval from the commissioner and compliance with subs. (5), (7) and (30), respectively.

2. Discloses on the first page any applicable ~~pre-existing~~ preexisting conditions limitation, contains no ~~pre-existing~~ preexisting condition waiting period longer than 6 months and ~~shall~~ does not define a ~~pre-existing~~ preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

3. Contains no definitions of terms such as "Medicare eligible expenses." "accident," "sickness," "mental or nervous disorders," "skilled nursing facility," "hospital," "nurse," "physician," ~~"Medicare approved expenses,"~~ "benefit period," "convalescent nursing home," or "outpatient prescription drugs" that are worded less favorably to the insured person than the corresponding Medicare definition or the definitions contained in sub. (3), and defines "Medicare" as in accordance with sub. (3) (q).

4. Does not indemnify against losses resulting from sickness on a different basis from losses resulting from accident~~;~~.

5. Is "guaranteed renewable" and does not provide for termination of coverage of a spouse solely because of an event specified for termination of coverage of the insured, other than the nonpayment of premium. The Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy shall not be cancelled or nonrenewed by the insurer on the grounds of deterioration of health. The Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy may be cancelled only for nonpayment of premium or material misrepresentation. If the Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy is issued by a health maintenance organization as defined by s. 609.01 (2), Stats., the policy or certificate may, in addition to the above reasons, be cancelled or nonrenewed by the issuer if the insured moves out of the service area~~;~~.

6. Provides that termination of a Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy ~~or certificate~~ shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force, although the

extension of benefits may be predicated upon the continuous total disability of the ~~insured~~ policyholder, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.

7. Contains statements on the first page and elsewhere in the Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy ~~which~~ that satisfy the requirements of s. Ins 3.13 (2) (c), (d) or (e), and clearly states on the first page or schedule page the duration of the term of coverage for which the policy or certificate is issued and for which it may be renewed. ~~(the~~The renewal period cannot be less than the ~~greater~~ greatest of the following: 3 months, the period ~~for which~~ the insured has paid the premium, or the period specified in the policy~~);~~ or certificate.

9. Prominently discloses any limitations on the choice of providers or geographical area of service~~;~~.

10. Contains on the first page the designation, printed in 18-point type, and in close conjunction the caption printed in 12-point type, prescribed in sub. (5), (7), or (30)~~;~~.

11. Contains text ~~which~~ that is plainly printed in black or blue ink ~~the~~ and has a font size ~~of which~~ that is uniform and not less than 10-point with a lower-case unspaced alphabet length not less than 120-point~~;~~.

12. Contains a provision ~~describing the review and appeal procedure for denied claims as required by s. 632.84, Stats., and a provision~~ describing any grievance rights as required by s. 632.83, Stats., applicable to Medicare supplement policy and certificate, Medicare select policy and certificate, and Medicare ~~replacement~~ cost policies~~; and~~.

16. Except for permitted preexisting condition clauses as described in subd. 2., no Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate, Medicare select policy or certificate or Medicare cost policy if

such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

18. A Medicare supplement policy or certificate, Medicare select policy or certificate or Medicare cost policy shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period not to exceed 24 months in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the ~~Social Security Act~~ social security act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to the assistance.

18p. Each Medicare supplement policy or certificate, Medicare select policy or certificate or Medicare cost policy shall provide, and contain within the policy, that benefits and premiums under the policy or certificate shall be suspended for any period that may be provided by federal regulation, at the request of the policyholder or certificateholder if the policyholder or certificateholder is entitled to benefits under section 226 (b) of the ~~Social Security Act~~ social security act and is covered under a group health plan, as defined in section 1862 (b)(1)(A)(v)of the ~~Social Security Act~~ social security act. If suspension occurs and if the policyholder or ~~certificate holder~~ certificateholder loses coverage under the group health plan, the policy or certificate shall be automatically reinstituted, effective as of the date of loss of coverage, if the policyholder or certificateholder provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

SECTION 32. INS 3.39 (4) (a) 18r. (intro.) is repealed.

SECTION 33. INS 3.39 (4) (a) 18r. a. to c. are renumbered INS 3.39 (4) (a) 18s., 18u., and 18x. and amended to read:

INS 3.39 (4) (a) 18s. ~~Shall~~ No Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy may ~~not~~ provide for any waiting period for resumption

of coverage that was in effect before the date of suspension under subd. 18. with respect to treatment of preexisting conditions.

18u. ~~Shall~~ Each Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy shall provide for resumption of coverage that was in effect before the date of suspension in subd. 18. If the suspended Medicare supplement policy or certificate, Medicare select policy or certificate or Medicare cost policy provided coverage for outpatient prescription drugs, ~~reinstitution~~ resumption of the policy shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension. If the suspended Medicare supplement policy or certificate, Medicare select policy or certificate or Medicare cost policy provided coverage of Medicare Part B medical deductible coverage or if the insured was enrolled or Medicare eligible prior to January 1, 2020, and the insurer offers a plan with Medicare Part B medical deductible coverage then the policyholder or certificateholder may elect or renew coverage with the Medicare Part B medical deductible coverage. If the insurer no longer offers a plan with the Medicare Part B medial deductible coverage, then the insurer shall provide the policyholder or certificateholder with substantially equivalent coverage to the coverage in effect prior to the date of suspension.

18x. ~~Shall~~ Each Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy shall provide ~~for~~ that upon the resumption of coverage that was in effect before the date of suspension in subd. 18. classification of premiums shall be on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

SECTION 34. INS 3.39 (4) (b) (intro.), and 1. to 7., (c), (e), and (g) are amended to read:

INS 3.39 (4) (b) The outline of coverage for the Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy or certificate~~.~~ shall comply with all of the following:

1. Is provided to all applicants at the time application is made and, except in the case of direct response insurance, the issuer obtains written acknowledgement from the applicant that the outline was received~~;~~.

2. Complies with s. Ins 3.27, including s. Ins 3.27 (5) (L) and (9) ~~(u) (v) and (zh) 2. and 4~~.

3. Is substituted to properly describe the Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy or certificate as issued, if the outline provided at the time of application did not properly describe the coverage which was issued. The substituted outline shall accompany the Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy or certificate when it is delivered and shall contain the following statement in no less than 12-point type and immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued."~~;~~

4. Contains in close conjunction on its first page the designation, printed in a distinctly contrasting color in 24-point type, and the caption, printed in a distinctly contrasting color in 18-point type prescribed in sub. (5), (7) or (30)~~;~~.

5. Is substantially in the format prescribed in Appendix 1 ~~to this section~~ for the appropriate category and printed in no less than 12-point type~~;~~.

6. Summarizes or refers to the coverage set out in applicable statutes~~;~~.

7. Contains a listing of the required coverage as set out in sub. (5) (c) and the optional coverages as set out in sub. (5) (i), and the annual premiums ~~therefor,~~ for each selected coverage, substantially in the format of sub. (11) of Appendix 1~~; and~~.

(c) Any rider or endorsement added to the Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy or certificate shall comply with all of the following:

1. Shall be ~~set forth~~ contained in the policy or certificate and, if a separate, additional premium is charged in connection with the rider or endorsement, the premium charge shall be ~~set forth~~ stated in the policy or certificate~~; and~~.

2. ~~After~~ Shall be agreed to in writing signed by the insured if, after the date of the Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy or certificate issue, ~~shall be agreed to in writing signed by the insured, if~~ the rider or endorsement increases benefits or coverage ~~with an~~ and there is an accompanying increase in premium during the term of the policy or certificate, unless the increase in benefits or coverage is required by law.

3. Shall only provide coverage as ~~defined~~ described in sub. (5) (i) or provide coverage to meet ~~statutory~~ Wisconsin mandated provisions.

(e) The anticipated loss ratio for any new Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy ~~or certificate~~ form, ~~that is,~~ or the expected percentage of the aggregate amount of premiums earned that will be returned to insureds in the form of aggregate benefits, not including anticipated refunds or credits, that is provided under the policy or certificate form:

1. Is computed on the basis of anticipated incurred claims or incurred health care expenses where coverage is provided by a health maintenance organizations on a service rather than reimbursement basis and earned premiums for the entire period for which the policy form provides coverage, in accordance with accepted actuarial principles and practices~~.~~; and

2. Is submitted to the commissioner along with the policy or certificate form and is accompanied by rates and an actuarial demonstration that expected claims in relationship to premiums comply with the loss ratio standards ~~in~~ under sub. (16) (d). The policy or certificate

form will not be approved by the commissioner unless the anticipated loss ratio along with the rates and actuarial demonstration show compliance with sub. (16) (d).

(g) ~~As regards~~ For subsequent rate changes to the policy or certificate form, the insurer shall do all of the following:

1. ~~Files such~~ File the rate changes ~~on a rate change transmittal form~~ in a format specified by the commissioner.

2. ~~Includes~~ Include in ~~its~~ the filing under subd. 1. an actuarially sound demonstration that the rate change will not result in a loss ratio over the life of the policy or certificate ~~which~~ that would violate the requirements under sub. (16) (d).

SECTION 35. INS 3.39 (4m) is renumbered INS 3.39 (3r) and INS 3.39 (3r) (a), (b) and (d) as renumbered, are amended to read:

INS 3.39 (3r) OPEN ENROLLMENT. **(a)** An issuer may not deny nor condition the issuance or effectiveness of, or discriminate in the pricing of, basic Medicare supplement ~~coverage~~ policies or certificates, Medicare cost policy, or Medicare select policies or certificates permitted, as applicable, under subs. (5), (5m), (5t), (7), ~~and~~ (30), (30m), (30t), or riders permitted under sub. (5) (i), (5m) (e), or (5t) (e), for which an application is submitted prior to or during the 6-month period beginning with the first month ~~in which~~ that an individual first enrolled for benefits under Medicare Part B or the month ~~in which~~ that an individual turns age 65 for any individual who was first enrolled in Medicare Part B when under the age of 65 on any of the following grounds:

(b) Except as provided in pars. (c) and (d), and sub. (34), this section shall not prevent the application of any ~~pre-existing~~ preexisting condition limitation that is in compliance with sub. (4) (a) 2.

(d) If the applicant qualifies under par. (a) and submits an application during the time period referenced in par. (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than 6 months, the issuer shall reduce the period of any ~~pre-existing~~ preexisting condition exclusion by the aggregate of the period of creditable coverage

applicable to the applicant as of the enrollment date. The ~~Secretary~~ secretary shall specify the manner of the reduction under this paragraph.

SECTION 36. INS 3.39 (4s) (intro.), (a) (intro.), and 1. to 20. are renumbered INS 3.39 (4m) (title), (intro.), (a) (intro.) and 1. to 20., and INS 3.39 (4m) (title), (intro.), (a) (intro.), 1., 3., 6., 11., and 12. as renumbered, are amended to read:

INS 3.39 (4m) MEDICARE SUPPLEMENT POLICY AND CERTIFICATE, MEDICARE SELECT POLICY AND CERTIFICATE, AND MEDICARE ~~REPLACEMENT~~ COST POLICY ~~AND CERTIFICATE~~ REQUIREMENTS FOR POLICIES AND CERTIFICATES OFFERED TO PERSONS FIRST ELIGIBLE FOR MEDICARE ON OR AFTER JUNE 1, 2010, AND PRIOR TO JANUARY 1, 2020. Except as explicitly allowed by subs. (5m) and (30m), no disability insurance policy or certificate shall relate its coverage to Medicare or be structured, advertised, marketed or issued to persons first eligible for Medicare on or after June 1, 2010, and prior to January 1, 2020, as a Medicare supplement policy or certificate, Medicare select policy or certificate, or as a Medicare ~~replacement~~ cost policy ~~or certificate, as defined in s. 600.03 (28p) (a) and (c), Stats.,~~ unless ~~it~~ the policy or certificate complies with all of the following:

(a) The policy or certificate shall comply with all of the following requirements:

1. Provides only the coverage set out in sub. (5m), (7), or (30m) and applicable statutes and contains no exclusions or limitations other than those permitted by sub. (8). No issuer may issue a Medicare cost policy or Medicare select policy or certificate without prior approval from the commissioner and compliance with sub. (30m).

3. Contains no definitions of terms such as "Medicare eligible expenses," "accident," "sickness," "mental or nervous disorders," skilled nursing facility," "hospital," "nurse," "physician," ~~"Medicare approved expenses,"~~ "benefit period," "convalescent nursing home," or "outpatient prescription drugs" that are worded less favorably to the insured person than the corresponding Medicare definition or the definitions contained in sub. (3), and defines "Medicare" as in accordance with sub. (3) (q).

6. Provides that termination of a Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy ~~or certificate~~ shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force, although the extension of benefits may be predicated upon the continuous total disability of the insured, limited to the duration of the policy or certificate benefit period, if any, or payment of the maximum benefits. Receipt of the Medicare Part D benefits may not be considered in determining a continuous loss.

11. Contains text that is plainly printed in black or blue ink ~~the size of which~~ and has a font size that is uniform and not less than 10-point type with a lower-case unspaced alphabet length not less than 120-point type.

12. Contains ~~a provision describing the review and appeal procedure for denied claims required by s. 632.84, Stats., and~~ a provision describing any grievance rights as required by s. 632.83, Stats., applicable to Medicare supplement policies and certificates and Medicare ~~replacement~~ cost policies ~~or certificates~~.

SECTION 37. INS 3.39 (4s) (a) 21. (intro.) is repealed.

SECTION 38. INS 3.39 (4s) (a) 21. a., b., and c. are renumbered INS 3.39 (4m) (a) 21e., 21m., and 21s. and amended to read:

INS 3.39 (4m) (a) 21e. ~~May~~ No Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy may ~~not~~ provide for any waiting period for resumption of coverage that was in effect before the date of suspension under subd. 18. with respect to treatment of preexisting conditions.

21m. ~~Shall~~ Each Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy shall provide for resumption of coverage that is substantially equivalent to coverage that was in effect before the date of suspension in subd. 18. If the suspended Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy provided coverage of Medicare Part B medical deductible coverage or if the

insured was enrolled or Medicare eligible prior to January 1, 2020, and the insurer offers a plan with Medicare Part B medical deductible coverage then resumption of the policy shall be with Medicare Part B medical deductible coverage. If the insurer no longer offers a plan with the Medicare Part B medical deductible coverage, then the insurer shall provide the insured with substantially equivalent coverage to the coverage in effect prior to the date of suspension.

21s. ~~Shall~~ Each Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy shall provide ~~for~~ that upon the resumption of coverage that was in effect before the date of suspension in subd. 18. classification of premiums shall be on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

SECTION 39. INS 3.39 (4s) (a) 22. and (b) to (f) are renumbered INS 3.39 (4m) (a) 22. and (b) to (f), and INS 3.39 (4m) (a) 22., (b) 5. and 7., (c) (intro.) and 1. and 2., and (d) to (f), as renumbered, are amended to read:

INS 3.39 (4m) (a) 22. May not use an underwriting standard during open enrollment for persons who are under age 65 that is more restrictive than the underwriting standards that are used for persons age 65 and ~~above~~ older.

(b) 5. Is substantially in the format prescribed in Appendices ~~3 through 6~~ 3m, 4m, 5m, and 6m, ~~to this section~~ for the appropriate category and printed in a font size that is ~~no~~ not less than 12-point type.

7. Contains a listing of the required coverage as set out in sub. (5m) (d) and the optional coverage as set out in sub. (5m) (e), and the annual premiums for each selected coverage, substantially in the format of sub. (11) in Appendix ~~2~~ 2m ~~to this section~~.

(c) Any rider or endorsement added to the policy or certificate shall ~~conform to the~~ comply with the following:

1. Shall be ~~set forth~~ contained in the policy or certificate and if a separate, additional premium is charged in connection with the rider or endorsement, the premium charge shall be ~~set forth~~ stated in the policy or certificate.

2. ~~After~~ Shall be agreed to in writing signed by the insured if, after the date of the policy or certificate issue, ~~shall be agreed to in writing signed by the insured, if~~ the rider or endorsement increases benefits or coverage ~~with an~~ and there is an accompanying increase in premium during the term of the policy or certificate, unless the increase in benefits or coverage is required by law.

(d) The schedule of benefits page or the first page of the policy or certificate contains a listing giving the coverages and both the annual premium in the format shown in sub. (11) of Appendix ~~2~~2m ~~to this section~~ and modal premium selected by the applicant.

(e) The anticipated loss ratio for any new policy or certificate form, ~~that is,~~ or the expected percentage of the aggregate amount of premiums earned that will be returned to insureds in the form of aggregate benefits, not including anticipated refunds or credits, that is provided under the policy or certificate form:

1. Is computed on the basis of anticipated incurred claims or incurred health care expenses where coverage is provided by a health maintenance organizations on a service rather than reimbursement basis and earned premiums for the entire period for which the policy form provides coverage, in accordance with accepted actuarial principles and practices~~.~~; and

2. Is submitted to the commissioner along with the policy or certificate form and is accompanied by rates and an actuarial demonstration that expected claims in relationship to premiums comply with the loss ratio standards ~~in~~ under sub. (16) (d). The policy or certificate form will not be approved by the commissioner unless the anticipated loss ratio along with the rates and actuarial demonstration show compliance with sub. (16) (d).

(f) ~~As regards~~ For subsequent rate changes to the policy or certificate form, the insurer shall do all of the following:

1. ~~Files such~~ File the rate changes on a rate change transmittal form in a format specified by the commissioner.

2. ~~Includes~~ Include in ~~its~~ the filing under subd. 1. an actuarially sound demonstration that the rate change will not result in a loss ratio over the life of the policy or certificate ~~which~~ that would violate the requirements under sub. (16) (d).

SECTION 40. INS 3.39 (4t) is created to read:

INS 3.39 (4t) MEDICARE SUPPLEMENT POLICY AND CERTIFICATE, MEDICARE SELECT POLICY AND CERTIFICATE, AND MEDICARE COST POLICY-REQUIREMENTS FOR POLICIES AND CERTIFICATES OFFERED TO PERSONS FIRST ELIGIBLE FOR MEDICARE ON OR AFTER JANUARY 1, 2020. (a) Except as explicitly allowed by subs. (5t), (7) and (30t), no disability insurance policy or certificate shall relate its coverage to Medicare or be structured, advertised, solicited, marketed or issued to persons newly eligible for Medicare on or after January 1, 2020, as a Medicare supplement policy or certificate, Medicare select policy or certificate, or as a Medicare cost policy unless the policy or certificate is in compliance with the following:

1. Provides only the coverage set out in sub. (5t), (7) or (30t), and applicable statutes, and contains no exclusions or limitations other than those permitted by sub. (8). No issuer may issue a Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy without prior approval from the commissioner and compliance with sub. (30t).

2. Discloses on the first page any applicable preexisting conditions limitation, contains no preexisting condition waiting period longer than 6 months and does not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

3. Contains no definitions of terms such as "Medicare eligible expenses," "accident," "sickness," "mental or nervous disorders, "skilled nursing facility," "hospital," "nurse," "physician," "benefit period," "convalescent nursing home," or "outpatient prescription drugs" that are worded

less favorably to the insured person than the corresponding Medicare definition or the definitions contained in sub. (3), and defines "Medicare" as in accordance with sub. (3) (q).

4. Does not indemnify against losses resulting from sickness on a different basis from losses resulting from accident.

5. Is guaranteed renewable and does not provide for termination of coverage of a spouse solely because of an event specified for termination of coverage of the insured, other than the non-payment of premium. The policy or certificate may not be cancelled or nonrenewed by the issuer on the grounds of deterioration of health. The policy or certificate may be cancelled only for nonpayment of premium or material misrepresentation. If the policy or certificate is issued by a health maintenance organization, the policy or certificate may, in addition to the above reasons, be cancelled or nonrenewed by the issuer if the insured moves out of the service area.

6. Provides that termination of a Medicare supplement policy or certificate or Medicare cost policy shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force, although the extension of benefits may be predicated upon the continuous total disability of the insured, limited to the duration of the policy or certificate benefit period, if any, or payment of the maximum benefits. Receipt of the Medicare Part D benefits may not be considered in determining a continuous loss.

7. Contains statements on the first page and elsewhere in the policy or certificate that satisfy the requirements of s. Ins 3.13 (2) (c), (d) and (e), and clearly states on the first page or schedule page the duration of the term of coverage for which the policy or certificate is issued and for which it may be renewed. The renewal period cannot be less than the greatest of the following: 3 months, the period the insured has paid the premium, or the period specified in the policy or certificate.

8. Changes benefits automatically to coincide with any changes in the applicable Medicare deductible amount, coinsurance, and copayment percentage factors, although there may be a

corresponding modification of premiums in accordance with the policy or certificate provisions and ch. 625, Stats.

9. Prominently discloses any limitations on the choice of providers or geographical area of service.

10. Contains on the first page the designation, printed in 18-point type, and in close conjunction the caption printed in 12-point type, prescribed in sub. (5t) or (30t).

11. Contains text that is plainly printed in black or blue ink and has a font size that is uniform and not less than 10-point type with a lower-case unspaced alphabet length not less than 120-point type.

12. Contains a provision describing any grievance rights as required by s. 632.83, Stats., applicable to Medicare supplement policies and certificates and Medicare cost policies.

13. Is approved by the commissioner.

14. Contains no exclusion, limitation, or reduction of coverage for a specifically named or described condition after the policy or certificate effective date.

15. Provides for midterm cancellation at the request of the insured and provides that, if an insured cancels a policy or certificate midterm or the policy or certificate terminates midterm because of the insured's death, the issuer shall issue a pro rata refund to the insured or the insured's estate.

16. Except for permitted preexisting condition clauses as described in subd. 2., no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

17. No Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy in force in this state shall contain benefits that duplicate benefits provided by Medicare.

18. A Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period not to exceed 24 months in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the social security act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to the assistance.

19. If the suspension in subd. 18. occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of the entitlement, if the policyholder or certificateholder provides notice of loss of the entitlement within 90 days after the date of the loss and pays the premium attributable to the period.

20. Each Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy shall provide, and contain within the policy or certificate, that benefits and premiums under the policy or certificate shall be suspended for any period that may be provided by federal regulation, at the request of the policyholder or certificateholder if the policyholder or certificateholder is entitled to benefits under section 226 (b) of the social security act and is covered under a group health plan, as defined in section 1862 (b) (1) (A)(v) of the social security act. If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy or certificate shall be automatically reinstituted, effective as of the date of loss of coverage, if the policyholder or certificateholder provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

21e. No Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy may provide for any waiting period for resumption of coverage that was in

effect before the date of suspension under subd. 18. with respect to treatment of preexisting conditions.

21m. Each Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy shall provide for resumption of coverage that is substantially equivalent to coverage that was in effect before the date of suspension in subd. 18. If the suspended Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy provided coverage of Medicare Part B medical deductible coverage or if the insured was enrolled or Medicare eligible prior to January 1, 2020, and the insurer offers a plan with Medicare Part B medical deductible coverage then resumption of the policy shall be with Medicare Part B medical deductible coverage. If the insurer no longer offers a plan with the Medicare Part B medical deductible coverage, then the insurer shall provide the insured with substantially equivalent coverage to the coverage in effect prior to the date of suspension.

21s. Each Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy shall provide for that upon the resumption of coverage that was in effect before the date of suspension in subd. 18. classification of premiums shall be on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

22. May not use an underwriting standard during open enrollment for persons who are under age 65 that is more restrictive than the underwriting standards that are used for persons age 65 and older.

(b) The outline of coverage for the policy or certificate shall comply with all of the following:

1. Is provided to all applicants at the same time application is made, and except in the case of direct response insurance, the issuer obtains written acknowledgement from the applicant that the outline was received.

2. Complies with s. Ins 3.27.

3. Is substituted to describe properly the policy or certificate as issued, if the outline provided at the time of application did not properly describe the coverage that was issued. The substituted outline shall accompany the policy or certificate when it is delivered and shall contain the following statement in no less than 12-point type and immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued."

4. Contains in close conjunction on its first page the designation, printed in a distinctly contrasting color or bold print in 24-point type, and the caption, printed in a distinctly contrasting color or bold print in 18-point type prescribed in sub. (5t), (7), or (30t).

5. Is substantially in the format prescribed in Appendices 3t, 4t, 5t, and 6t, for the appropriate category and printed in a font size that is not less than 12-point type.

6. Summarizes or refers to the coverage set out in applicable statutes.

7. Contains a listing of the required coverage as set out in sub. (5t) (d), and the optional coverage as set out in sub. (5t) (e), and the annual premiums for each selected coverage, substantially in the format of sub. (11) in Appendix 2t.

8. Is approved by the commissioner along with the policy or certificate form.

(c) Any rider or endorsement added to the policy or certificate shall comply with all of the following:

1. Shall be contained in the policy or certificate and if a separate, additional premium is charged in connection with the rider or endorsement, the premium charge shall be stated in the policy or certificate.

2. Shall be agreed to in writing signed by the insured if, after the date of the policy or certificate issue, the rider or endorsement increases benefits or coverages and there is an accompanying increase in premium during the term of the policy or certificate, unless the increase in benefits or coverage is required by law.

3. Shall only provide coverage as described in sub. (5t) (e), or provide coverage to meet Wisconsin mandated benefits.

(d) The schedule of benefits page or the first page of the policy or certificate contains a listing giving the coverages and both the annual premium in the format shown in sub. (11) of Appendix 2t and modal premium selected by the applicant.

(e) The anticipated loss ratio for any new policy or certificate form, or the expected percentage of the aggregate amount of premiums earned that will be returned to insureds in the form of aggregate benefits, not including anticipated refunds or credits, that is provided under the policy or certificate form:

1. Is computed on the basis of anticipated incurred claims or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the entire period that the policy or certificate form provides coverage, in accordance with accepted actuarial principles and practices; and

2. Is submitted to the commissioner along with the policy or certificate form and is accompanied by rates and an actuarial demonstration that expected claims in relationship to premiums comply with the loss ratio standards under sub. (16) (d). The policy or certificate form will not be approved by the commissioner unless the anticipated loss ratio along with the rates and actuarial demonstration show compliance with sub. (16) (d).

(f) For subsequent rate changes to the policy or certificate form, the issuer shall do all of the following:

1. File the rate changes on a rate change transmittal form in a format specified by the commissioner.

2. Include in the filing under subd.1. an actuarially sound demonstration that the rate change will not result in a loss ratio over the life of the policy or certificate that would violate the requirements under sub. (16) (d).

SECTION 41. INS 3.39 (5) (title), (intro.) (c) (intro.), (n) 12., (o) 12., and (5m) (title) are amended to read:

INS 3.39 (5) AUTHORIZED MEDICARE SUPPLEMENT POLICY AND CERTIFICATE DESIGNATION, CAPTIONS, REQUIRED COVERAGES, AND PERMISSIBLE ADDITIONAL BENEFITS FOR POLICIES OR CERTIFICATES ~~EFFECTIVE~~ OFFERED TO PERSONS FIRST ELIGIBLE FOR MEDICARE PRIOR TO JUNE 1, 2010. ~~For~~ This subs. applies only to a Medicare supplement policy or certificate ~~to meet~~ that meets the requirements of sub. (4), that is issued or effective after December 31, 1990, and prior to June 1, 2010, and that ~~it~~ shall contain the authorized designation, caption and required coverage. A health maintenance organization shall place the letters HMO in front of the required designation on any approved Medicare supplement policy or certificate. A Medicare supplement policy or certificate shall include all of the following:

(c) The following required coverages, to be referred to as "Basic Medicare Supplement coverage" for a policy issued to persons first eligible for Medicare after December 31, 1990 and prior to June 1, 2010, shall comply with all the following:

(n) 12. Coverage of 100% of all cost sharing under Medicare Part A or B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the ~~Secretary~~ secretary.

(o) 12. Coverage of 100% of all cost sharing under Medicare Part A or B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $2,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the ~~Secretary~~ secretary.

(5m) (title) AUTHORIZED MEDICARE SUPPLEMENT POLICY AND CERTIFICATE DESIGNATION, CAPTIONS, REQUIRED COVERAGES, AND PERMISSIBLE ADDITIONAL BENEFITS FOR POLICIES OR CERTIFICATES ~~WITH EFFECTIVE DATES~~ OFFERED TO PERSONS FIRST ELIGIBLE FOR MEDICARE ON OR AFTER JUNE 1, 2010 AND PRIOR TO JANUARY 1, 2020.

SECTION 42. INS 3.39 (5m) (a) (intro.) is created to read:

INS 3.39 (5m) (a) All of the following standards are applicable to a Medicare supplement policy or certificate that is delivered or issued to persons first eligible for Medicare on or after June 1, 2010 and prior to January 1, 2020:

SECTION 43. INS 3.39 (5m) (a) 1. is renumbered INS 3.39 (5m) (a) 1. (intro.) and amended to read:

INS 3.39 (5m) (a) 1. ~~The following standards are applicable to all Medicare supplement policies or certificates delivered or issued in this state.~~ No policy or certificate may be advertised, solicited, delivered, or issued ~~for delivery in this state~~ to persons first eligible for Medicare on or after June 1, 2010 and prior to January 1, 2020 as a Medicare supplement policy or certificate unless it complies with these benefit standards. ~~Benefit standards applicable to Medicare supplement policies and certificates with effective dates prior to June 1, 2010 remain subject to the applicable requirements contained in sub. (5).~~ All of the following standards are applicable to Medicare supplement policies or certificates, delivered or issued in this state:

SECTION 44. INS 3.39 (5m) (a) 1. b. is created to read:

INS 3.39 (5m) (a) 1. b. Benefit standards applicable to Medicare supplement policies and certificates, issued to a person first eligible for Medicare prior to June 1, 2010, remain subject to the applicable requirements contained in sub. (5).

SECTION 45. INS 3.39 (5m) (a) 2. (intro.) is amended to read:

INS 3.39 (5m) (a) 2. For a policy or certificate to meet the requirements of sub. ~~(4s)~~ (4m), it shall contain the authorized designation, caption and required coverage. ~~A health maintenance organization shall place the letters HMO in front of the required designation on any approved Medicare supplement policy or certificate.~~ A Medicare supplement policy or certificate shall include all of the following:

SECTION 46. INS 3.39 (5m) (b) and (c) are renumbered INS 3.39 (5m) (a) 2. a. and b. and INS 3.39 (5m) (a) 2. b. as renumbered, is amended to read:

INS 3.39 (5m) (a) 2. b. The following caption, except that the word "certificate" may be used instead of "policy," if appropriate: "The Wisconsin Insurance Commissioner has set standards for Medicare supplement insurance. This policy meets these standards. It, along with Medicare, may not cover all of your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see 'Wisconsin Guide to Health Insurance for People with Medicare,' given to you when you applied for this policy. Do not buy this policy if you did not get this guide."

SECTION 47. INS 3.39 (5m) (e) is amended to read:

INS 3.39 (5m) (e) Permissible coverage options may only be added to the policy or certificate as separate riders. The issuer shall issue a separate rider for each option offered. Issuers shall ensure that the riders offered are compliant with MMA, each rider is priced separately, available for purchase separately at any time, subject to underwriting and the preexisting limitation allowed in sub. ~~(4s)~~ (4m) (a) 2. The issuer shall not issue to the same insured for the same period of coverage both the Medicare Part A Deductible rider and the Medicare 50% Part A Deductible rider. The issuer shall not issue to the same insured for the same period of coverage both the Medicare Part B Deductible rider and the Medicare Part B Copayment or Coinsurance rider. Separate riders, if offered, shall consist of the following:

SECTION 48. INS 3.39 (5m) (g) 12., (h) 12., and (k) 4. are amended to read:

INS 3.39 (5m) (g) 12. Coverage for 100% of all cost sharing under Medicare Part A or B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of [$4,440], indexed each year by the appropriate inflation adjustment specified by the ~~Secretary~~ secretary.

(h) 12. Coverage for 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of [$2,220], indexed each year by the appropriate inflation adjustment specified by the ~~Secretary~~ secretary.

(k) 4. The annual high deductible shall be $2000 and shall be adjusted annually by the ~~Secretary of the U.S. Department of Health and Human Services~~ secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

SECTION 49. INS 3.39 (5t) is created to read:

INS 3.39 (5t) AUTHORIZED MEDICARE SUPPLEMENT POLICY AND CERTIFICATE DESIGNATION, CAPTIONS, REQUIRED COVERAGES, AND PERMISSIBLE ADDITIONAL BENEFITS FOR POLICIES OR CERTIFICATES OFFERED TO PERSONS FIRST ELIGIBLE FOR MEDICARE ON OR AFTER JANUARY 1, 2020. **(a)** All of the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020:

1. Policies or certificates issued to persons newly eligible for Medicare on or after January 1, 2020, shall not provide an option to elect coverage of the Medicare Part B medical deductible rider.

2. Insurers may continue to sell and renew policies and certificates that contain the Medicare Part B medical deductible benefit or rider to Medicare eligible persons who were first eligible for Medicare prior to January 1, 2020.

(b) 1. No Medicare supplement policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. All of the following standards are applicable to Medicare supplement policies or certificates delivered or issued in this state.

a. Benefit standards applicable to Medicare supplement policies and certificates issued to persons first eligible for Medicare prior to June 1, 2010, remain subject to the applicable requirements contained in sub. (5).

b. Benefit standards applicable to Medicare supplement policies and certificates issued to persons first eligible for Medicare on or after June 1, 2010, and prior to January 1, 2020, remain subject to the applicable requirements contained in sub. (5m).

2. Policies or certificates shall contain the authorized designation, caption and required coverage in order to meet the requirements of sub. (4t). A Medicare supplement policy or certificate shall include all of the following:

a. The designation: **MEDICARE SUPPLEMENT INSURANCE**.

b. The following caption, except that the word "certificate" may be used instead of "policy," if appropriate: "The Wisconsin Insurance Commissioner has set standards for Medicare supplement insurance. This policy meets these standards. It, along with Medicare, may not cover all of your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see 'Wisconsin Guide to Health Insurance for People with Medicare,' given to you when you applied for this policy. Do not buy this policy if you did not get this guide."

(d) All of the following required coverages shall be referred to as "Basic Medicare Supplement Coverage:"

1. Coverage of at least 175 days per lifetime for inpatient psychiatric hospital care upon exhaustion of Medicare hospital inpatient psychiatric coverage.

2. Coverage of coinsurance or copayments for Medicare Part A eligible expenses in a skilled nursing facility from the 21st through the 100th day in a benefit period.

3. Coverage for all Medicare Part A eligible expenses for the first 3 pints of blood or equivalent quantities of packed red blood cells to the extent not covered by Medicare.

4. Coverage of coinsurance or copayments for all Medicare Part A eligible expenses for hospice and respite care.

5. Coverage of coinsurance or copayment for Medicare Part B eligible expenses to the extent not paid by Medicare, or in the case of hospital outpatient department services paid under

a prospective payment system including outpatient psychiatric care, regardless of hospital confinement, subject to the Medicare Part B calendar year deductible.

6. Coverage for the usual and customary home care expenses to a minimum of 40 visits per 12-month period as required under s. 632.895 (2) (d), Stats., and s. Ins 3.54.

7. Coverage for skilled nursing care and kidney disease treatment as required under s. 632.895 (3) and (4), Stats. Coverage for skilled nursing care shall be in addition to the required coverage under subd. 1. Payment of coinsurance or copayment for Medicare Part A eligible skilled nursing care may not count as satisfying the coverage requirement of at least 30 days of non-Medicare eligible skilled nursing care under s. 632.895 (3), Stats.

8. In group policies, coverage for nervous and mental disorders and alcoholism and other drug abuse coverage as required under s. 632.89, Stats.

9. Coverage in full for all usual and customary expenses for chiropractic services consistent with s. 632.87 (3), Stats. Issuers are not required to duplicate benefits paid by Medicare.

10. Coverage of the first 3 pints of blood payable under Medicare Part B.

11. Coverage of Medicare Part A eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

12. Coverage of Medicare Part A eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days.

13. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of all Medicare Part A eligible expenses for hospitalization not covered by Medicare for an additional 365 days to the extent the hospital is permitted to charge Medicare by federal law and regulation and subject to the Medicare reimbursement rate and a lifetime maximum benefit. The provider shall accept the issuer's payment as payment in full and may not balance bill the insured.

14. Coverage in accordance with s. 632.895 (6), Stats., for treatment of diabetes including non-prescription insulin or any other non-prescription equipment and supplies for the treatment of diabetes, but not including any other outpatient prescription medications. Issuers are not required to duplicate expenses paid by Medicare.

15. Coverage for preventive health care services not covered by Medicare and as determined to be medically appropriate by an attending physician. These benefits shall be included in the basic policy or certificate. Reimbursement shall be for the actual charges up to 100% of the Medicare approved amount for each service, as if Medicare were to cover the service, as identified in the American Medical Association Current Procedural Terminology codes, to a minimum of $120 annually under this benefit. This benefit may not include payment for any procedure covered by Medicare.

16. Coverage in full for all usual and customary expenses of hospital and ambulatory surgery center charges and anesthetics for dental care required by s. 632.895 (12), Stats. Issuers are not required to duplicate benefits paid by Medicare.

17. Coverage in full for all usual and customary expenses for breast reconstruction required by s. 632.895 (13), Stats. Issuers are not required to duplicate benefits paid by Medicare.

(e) Permissible coverage options may only be added to the policy or certificate as separate riders. The issuer shall issue a separate rider for each option offered. Issuers shall ensure that the riders offered are compliant with MACRA and each rider is priced separately, available for purchase separately at any time, subject to underwriting and the preexisting limitation allowed in sub. (4t) (a) 2. The issuer shall not issue to the same insured for the same period of coverage both the Medicare Part A deductible rider and the Medicare 50% Part A deductible rider. If separate riders are offered, the separate riders shall only consist of any of the following riders:

1. Coverage of 100% of the Medicare Part A hospital deductible. The rider shall be designated as: MEDICARE PART A DEDUCTIBLE RIDER.

2. Coverage of 50% of the Medicare Part A hospital deductible per benefit period with no out-of-pocket maximum. The rider shall be designated as: MEDICARE 50% PART A DEDUCTIBLE RIDER.

3. Coverage of home health care for an aggregate of 365 visits per policy or certificate year as required by s. 632.895 (2) (e), Stats. The rider shall be designated as: ADDITIONAL HOME HEALTH CARE RIDER.

4. Coverage of Medicare Part B Copayment or Coinsurance Rider. Under this rider, the insured's copayment or coinsurance will be the lesser of $20 per office visit or the Medicare Part B coinsurance and the lesser of $50 per emergency room visit or the Medicare Part B coinsurance that is in addition to the Medicare Part B medical deductible. The emergency room copayment or coinsurance fee shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense. The rider shall be designated as: MEDICARE PART B COPAYMENT OR COINSURANCE RIDER.

5. Coverage of the difference between Medicare Part B eligible charges and the amount charged by the provider that shall be no greater than the actual charge or the limiting charge allowed by Medicare. The rider shall be designated as: MEDICARE PART B EXCESS CHARGES RIDER.

6. Coverage for services obtained outside the United States. An issuer that offers this rider may not limit coverage to Medicare deductibles, coinsurance and copayments. Coverage may contain a deductible of up to $250. Coverage shall pay at least 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country; care that would have been covered by Medicare if provided in the United States; and when the care began during the first 60 consecutive days of each trip outside the United States for up to a lifetime maximum benefit of at least $50,000. For purposes of this rider, "emergency hospital, physicians and medical care" shall mean care needed

immediately because of an injury or an illness of sudden and unexpected onset. The rider shall be designated as: FOREIGN TRAVEL EMERGENCY RIDER.

(f) For HMO Medicare select policies, only the benefits specified in sub. (30t) (p), (r) and (s), may be offered in addition to Medicare benefits.

(g) For Medicare supplement 50% Cost-Sharing plans, all of the following shall be included:

1. The designation: **Medicare Supplement 50% cost-sharing plan**.

2. Coverage of coinsurance or copayment for Medicare Part A hospital amount for each day used from the 61st through the 90th day in any Medicare benefit period.

3. Coverage of coinsurance or copayment of Medicare Part A hospital amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period.

4. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage for 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime limitation benefit of an additional 365 days.

5. Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation as described in subd. 12. is met.

6. Coverage for 50% of the coinsurance or copayment amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation as described in subd. 12. is met.

7. Coverage for 50% of coinsurance or copayments for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation as described in subd. 12. is met.

8. Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal

regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation as described in subd. 12. is met.

9. Except for coverage provided in subd. 11., coverage for 50% of the coinsurance or copayment otherwise applicable under Medicare Part B after the policyholder or certificateholder pays the Medicare Part B deductible until the out-of-pocket limitation as described in subd. 12. is met.

10. Coverage for 100% of the coinsurance or copayments for the benefits described in pars. (d) 1., 6., 7., 9., 14., 16., and 17., and (e) 3., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder or certificateholder pays the Medicare Part A and B deductibles and the out-of-pocket limitation described in subd. 12. is met.

11. Coverage for 100% of the coinsurance or copayments for Medicare Part B preventive services after the policyholder or certificateholder pays the Medicare Part B deductible.

12. Coverage for 100% of all cost sharing under Medicare Part A or B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B indexed each year by the appropriate inflation adjustment specified by the secretary.

(h) For Medicare Supplement 25% Cost-Sharing plans, all of the following shall be included:

1. The designation: **Medicare Supplement 25% cost-sharing plan**.

2. Coverage for 100% of the Medicare Part A hospital coinsurance or copayment amount for each day used from the 61st through the 90th day in any Medicare benefit period.

3. Coverage for 100% of the Medicare Part A hospital coinsurance or copayment amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period.

4. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage for 100% of the Medicare Part A eligible expenses for hospitalization paid

at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime limitation benefit of an additional 365 days.

5. Coverage for 75% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation as described in subd. 12. is met.

6. Coverage for 75% of the coinsurance or copayment amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation as described in subd. 12. is met.

7. Coverage for 75% of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation as described in subd. 12. is met.

8. Coverage for 75%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation as described in subd. 12. is met.

9. Except for coverage provided in subd. 11., coverage for 75% of the cost sharing otherwise applicable under Medicare Part B, after the policyholder or certificateholder pays the Medicare Part B deductible until the out-of-pocket limitation as described in subd. 12. is met.

10. Coverage for 100% of the cost sharing for the benefits described in pars. (d) 1., 6., 7., 9., 14., 16., and 17., and (e) 3., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder or certificateholder pays the Medicare Part A and B deductible and the out-of-pocket limitation described in subd. 12. is met.

11. Coverage for 100% of the cost sharing for Medicare Part B preventive services after the policyholder or certificateholder pays the Medicare Part B deductible.

12. Coverage for 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual

expenditures under Medicare Parts A and B indexed each year by the appropriate inflation adjustment specified by the secretary.

(k) For the Medicare supplement high deductible plan, all of the following shall be included:

1. The designation: **MEDICARE SUPPLEMENT INSURANCE-HIGH DEDUCTIBLE PLAN.**

2. Coverage for 100% of benefits described in pars. (d) and (e) 1., 3., 5., and 6., following the payment of the annual high deductible.

3. The annual high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered in subd. 2 and shall be in addition to any other specific benefit deductibles.

4. The annual high deductible shall be $2000 and shall be adjusted annually by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(L) Nothing in this section shall be construed to prohibit an insurer from discontinuing the marketing of policies offered under subs. (5m), (5t), (7), (30m), or (30t).

SECTION 50. INS 3.39 (6) (intro.), is amended to read:

INS 3.39 (6) An issuer can only include a policy or certificate provision limiting benefits to the usual, customary and reasonable charge as determined by the issuer for coverages described in subs. (5) (c) 5., 8. and 13., ~~or~~ (5m) (d) 6., 9., and 14., or (5t) (d) 6., 9., and 14. If the issuer includes such a provision, the issuer shall:

SECTION 51. INS 3.39 (7) (title), (a) (intro.), (b) (intro.), 1. (intro.) c., and 2., (c), and (cm) are amended to read:

INS 3.39 (7) AUTHORIZED MEDICARE ~~REPLACEMENT~~ COST POLICY ~~AND CERTIFICATE~~ DESIGNATION, CAPTIONS AND REQUIRED MINIMUM COVERAGES.

(a) A Medicare cost policy ~~or certificate~~ that is issued by an issuer that has a cost contract with CMS for Medicare benefits shall meet the standards and requirements of sub. (4) and shall contain all of the following required coverages, to be referred to as "Basic Medicare cost coverage" for a policy ~~or certificate~~ issued to persons first eligible for Medicare after January 1, 2005, and prior to June 1, 2010.

(b) Medicare ~~replacement~~ cost policies~~, as defined in s. 600.03 (28p) (a) and (c), Stats.,~~ are exempt from the provisions of s. 632.73 (2m), Stats., and are subject to all of the following:

1. Medicare ~~replacement~~ cost policies shall permit members to disenroll at any time for any reason. Premiums paid for any period of the policy beyond the date of disenrollment shall be refunded to the member on a pro rata basis. A Medicare ~~replacement~~ cost policy shall include a written provision providing for the right to ~~disenrolls which~~ disenroll that shall contain all of the following:

c. Include the following language or substantially similar language approved by the commissioner. "You may ~~disenrolls form~~ disenroll from the plan at any time for any reason. However, it may take up to 60 days to return you to the regular Medicare program. Your disenrollment will become effective on the day you return to regular Medicare. You will be notified by the plan of the date ~~on which~~ that your disenrollment becomes effective. The plan will return any unused premium to you on a pro rata basis."

2. The Medicare ~~replacement~~ cost policy may require requests for disenrollment to be in writing. Enrollees may not be required to give their reasons for disenrolling, or to consult with an agent or other representative of the issuer before disenrolling.

(c) ~~Each~~ For Medicare cost policies issued to persons first eligible for Medicare prior to June 1, 2010, each issuer offering Medicare cost ~~issuer, as defined in s. 600.03 (28p) (a) and (c), Stats.,~~ policies may offer an enhanced Medicare cost ~~plan~~ policy that ~~contain~~ contains the coverage ~~contained~~ described in sub. (5) (c) 5., 6., 7., 8., 13., 15., 16., 17., and the riders described in sub. (5) (i).

(cm) For Medicare cost policies issued to persons first eligible for Medicare on or after June 1, 2010, and prior to January 1, 2020, each issuer offering Medicare cost ~~issuer, as defined in s. 600.03 (28p) (a) and (c), Stats.,~~ policies may offer an enhanced Medicare cost ~~plan~~ policy that ~~contain~~ contains the coverage ~~contained~~ described in sub. (5m) (d) 6., 7., 8., 10., 14., 16., 17., and the riders described in sub. (5m) (e) ~~and other coverage as authorized by CMS~~.

SECTION 52. INS 3.39 (7) (ct) is created to read:

INS 3.39 (7) (ct) For Medicare cost policies issued to individuals newly eligible for Medicare on or after January 1, 2020, each issuer offering Medicare cost policies may offer an enhanced Medicare cost policy that contains the coverage described in sub. (5t) (d) 6., 7., 8., 10., 14., 16. and 17., and the riders described in sub. (5t) (e).

SECTION 53. INS (7) (dm) is amended to read:

INS 3.39 (7) (dm) For Medicare cost policies issued to persons first eligible for Medicare on or after June 1, 2010, and prior to January 1, 2020, in addition to all other subsections that are applicable to Medicare cost policies, the marketing of Medicare cost policies shall comply with the requirements of Medicare supplement policies contained in subs. (15), (21), (24), and (25). The outline of coverage listed in Appendix ~~2~~2m and the replacement form specified in Appendix 7 shall be modified to accurately reflect the benefits, exclusions and other requirements that differ from Medicare supplement policies approved under sub. (5m).

SECTION 54. INS 3.39 (7) (dt) is created to read:

INS 3.39 (7) (dt) For Medicare cost policies issued to persons newly eligible for Medicare on or after January 1, 2020, in addition to all other subsections that are applicable to Medicare cost policies, the marketing of Medicare cost policies shall comply with the requirements of Medicare supplement policies contained in subs. (15), (21), (24), and (25). The outline of coverage listed in Appendix 2t and the replacement form specified in Appendix 7 shall be modified to accurately reflect the benefits, exclusions and other requirements that differ from Medicare supplement policies approved under sub. (5t).

SECTION 55. INS 3.39 (8) (title), (a) (intro.), (c), and (e), (10) (a) and (d) 1., (13), (14) (a), (c) (intro.) 1. to 6., (d), (i), and (L), (14m) (title), (a), and (c) 1. to 6., are amended to read:

INS 3.39 (8) (title) PERMISSIBLE MEDICARE SUPPLEMENT POLICY AND CERTIFICATE, MEDICARE SELECT POLICY AND CERTIFICATE, AND MEDICARE ~~REPLACEMENT~~ COST POLICY ~~OR CERTIFICATE~~ EXCLUSIONS AND LIMITATIONS. **(a)** The coverage set out in subs. (5), (5m), (5t), (7), (30), ~~and~~ (30m), and (30t), as applicable:

(c) The coverages set out in subs. (5), (5m), (5t), (7), (30), ~~and~~ (30m), and (30t) may not exclude, limit, or reduce coverage for specifically named or described preexisting diseases or physical conditions, except as provided in par. (a) 3.

(e) A Medicare ~~replacement~~ cost policy, ~~and~~ Medicare supplement policy or certificate and Medicare select policy or certificate may include other exclusions and limitations ~~which~~ that are not otherwise prohibited and are not more restrictive than exclusions and limitations contained in Medicare.

(10) (a) ~~Conversion requirements~~ *Conversion requirements*. An insured under individual, family, or group hospital or medical coverage who will become eligible for Medicare and is offered a conversion policy which is not subject to subs. (4), (4m), (4t), ~~and~~ (5), (5m), (5t) or (7) shall be furnished by the issuer, at the time the conversion application is furnished in the case of individual or family coverage or within 14 days of a request in the case of group coverage.

(d) 1. For a conversion policy which relates its benefits to or complements Medicare, shall comply with sub. (4) (b) 2., 5., and 7., (4m) (b) 2., 5., 7., or (4t) (b) 2., 5., 7. of this section and shall be submitted to the commissioner; and

(13) EXEMPTION OF CERTAIN POLICIES AND CERTIFICATES FROM CERTAIN STATUTORY MEDICARE SUPPLEMENT REQUIREMENTS. Policies and certificates ~~defined~~ described in sub. (2) (d), even if they are Medicare supplement ~~policies as defined in s. 600.03 (28r), Stats.,~~ and Medicare select, policies as described in s. 600.03 (28r), Stats., or Medicare ~~replacement~~ cost policies as

~~defined~~ described in s. 600.03 (28p) (a) and (c), Stats., shall not be subject to either of the following:

(a) The special right of return provision for Medicare supplement, Medicare select, or Medicare cost policies set forth in s. 632.73 (2m), Stats., and s. Ins 3.13 (2) (j) 3.

(b) The special ~~pre-existing~~ preexisting disease provisions for Medicare supplement, Medicare select, or Medicare cost policies set forth in s. 632.76 (2) (b), Stats.

(14) (a) Each issuer issuing policies or certificates ~~with effective dates~~ to persons first eligible for Medicare prior to June 1, 2010, may file and utilize only one individual Medicare supplement policy form, one individual Medicare select policy form, one individual Medicare ~~replacement~~ cost policy form, one group Medicare select certificate form and one group Medicare supplement ~~policy~~ certificate form with any of the accompanying riders permitted in sub. (5) (i), unless the commissioner approves the use of additional forms and the issuer agrees to aggregate experience for the various forms in calculating rates and loss ratios.

(c) An issuer shall comply with section 1882 (c) (3) of the ~~Social Security Act~~ social security act, as enacted by section 4081 (b) (2) (C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203, by complying with all of the following:

1. Accepting a notice from a Medicare ~~carrier~~ issuer on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice~~;~~.

2. Notifying the participating physician or supplier and the beneficiary of the payment determination~~;~~.

3. Paying the participating physician or supplier directly~~;~~.

4. Furnishing, at the time of enrollment, each ~~enrollee~~ insured with a card listing the policy name, number and a central mailing address to which notices from a Medicare ~~carrier~~ issuer may be sent~~;~~.

5. Paying user fees for claim notices that are transmitted electronically or otherwise;

6. Providing to the ~~Secretary~~ secretary, at least annually, a central mailing address to which all claims may be sent by Medicare ~~carriers; and~~ issuers.

(d) Except as provided in subd. 1., an issuer shall continue to make available for purchase any Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy form or certificate form issued after August 1, 1992 that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

1. An issuer may discontinue the availability of a Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the discontinued policy form or certificate for in this state.

2. An issuer that discontinues the availability of a Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy form or certificate form pursuant to subd. 1., shall not file for approval a new policy form or certificate form for a period of 5 years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(i) No issuer may issue a Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy to an applicant 75 years of age or older, unless the applicant is subject to sub. ~~(4m)~~(3r) or, prior to issuing coverage, the issuer either agrees not to rescind or void the policy or certificate except for intentional fraud in the application, or obtains one of the following:

(L) For policies issued to persons first eligible for Medicare between December 31, 1980, and January 1, 1992, issuers shall combine the Wisconsin experience of all policy forms of the

same type ~~(individual or group)~~ as defined at sub. (3) (zar), for the purpose of calculating the loss ratio under sub. (16) (c) and rates. The rates for all such policies or certificates of the same type shall be adjusted by the same percentage. Issuers may combine the Wisconsin experience of all policies issued prior to January 1, 1981, with those issued between December 31, 1980, and January 1, 1992, if the issuer uses the 60% loss ratio for individual policies and the 70% loss ratio for group policies renewed prior to January 1, 1996, and the appropriate loss ratios specified in sub. (16) (d) thereafter. For policies issued on or after January 1, 1992, and prior to June 1, 2010, issuers shall combine the Wisconsin experience of all policy or certificate forms of the same type, for the purpose of calculating the amount of refund or premium credit, if any, if the issuer uses the 65% loss ratio for individual policies and the 75% loss ratio for group certificates renewed on or after January 1, 1996, and prior to June 1, 2010, and the appropriate loss ratios specified in sub. (16) (d). If the Wisconsin experience is not credible, then national experience can be considered.

(14m) OTHER REQUIREMENTS FOR POLICIES OR CERTIFICATES ~~WITH EFFECTIVE DATES~~ ISSUED TO PERSONS FIRST ELIGIBLE FOR MEDICARE ON OR AFTER JUNE 1, 2010, AND PRIOR TO JANUARY 1, 2020. **(a)** Each issuer issuing policies or certificates ~~with effective dates~~ to persons first eligible for Medicare on or after June 1, 2010, and prior to January 1, 2020, may file and utilize only one individual Medicare supplement policy ~~or certificate~~ form, one individual Medicare select policy ~~or certificate~~ form, one individual Medicare ~~replacement~~ cost policy ~~or certificate~~ form, one group Medicare select certificate form, and one group Medicare supplement ~~policy or~~ certificate form with any of the accompanying riders permitted in sub. (5m) (e), unless the commissioner approves the use of additional forms and the issuer agrees to aggregate experience for the various forms in calculating rates and loss ratios.

(c) 1. Accepting a notice from a Medicare ~~carrier~~ issuer on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other

claim form otherwise required and making a payment determination on the basis of the information contained in that notice~~;~~.

2. Notifying the participating physician or supplier and the beneficiary of the payment determination~~;~~.

3. Paying the participating physician or supplier directly~~;~~.

4. Furnishing, at the time of enrollment, each ~~enrollee~~ insured with a card listing the policy or certificate name, number and a central mailing address to which notices from a Medicare ~~carrier~~ issuer may be sent~~;~~.

5. Paying user fees for claim notices that are transmitted electronically or otherwise~~;~~.

6. Providing to the ~~Secretary~~ secretary, at least annually, a central mailing address to which all claims may be sent by Medicare ~~carriers; and~~ issuers.

SECTION 56. INS 3.39 (14m) (d) (intro.) 1. to 3. are renumbered INS 3.39 (14m) (d) 1. to 4. and INS 3.39 (14m) (d) 1. and 3., as renumbered, are amended to read:

INS 3.39 (14m) (d) 1. Except as provided in subd. ~~1.~~2., an issuer shall continue to make available for purchase any policy or certificate form issued to persons first eligible for Medicare after May 31, 2010, and prior to January 1, 2020, that has been approved by the commissioner. A policy or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

3. An issuer that discontinues the availability of a policy or certificate form pursuant to subd. ~~1.~~2., shall not file for approval a new policy form or certificate form of the same type, as defined at subd. (3) (zar), as the discontinued form for a period of 5 years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

SECTION 57. INS 3.39 (14m) (i) (intro.) is amended to read:

INS 3.39 (14m) (i) No issuer may issue a Medicare supplement policy or certificate, a Medicare select policy or certificate, or a Medicare cost policy to an applicant 75 years of age or

older, unless the applicant is subject to sub. ~~(4m)~~(3r) or, prior to issuing coverage, the issuer either agrees not to rescind or void the policy or certificate except for intentional fraud in the application, or obtains one of the following:

SECTION 58. INS 3.39 (14t) is created to read:

INS 3.39 (14t) OTHER REQUIREMENTS FOR MEDICARE SUPPLEMENT POLICIES OR CERTIFICATES, MEDICARE SELECT POLICIES OR CERTIFICATES, OR MEDICARE COST POLICIES TO PERSONS NEWLY ELIGIBLE FOR MEDICARE ON OR AFTER JANUARY 1, 2020. **(a)** Each issuer issuing policies or certificates to persons newly eligible for Medicare on or after January 1, 2020, may file and utilize only one individual Medicare supplement policy form, one individual Medicare select policy form, one individual Medicare cost policy form, one group Medicare select certificate form, and one group Medicare supplement certificate form with any of the accompanying riders permitted in sub. (5t) (e), unless the commissioner approves the use of additional forms and the issuer agrees to aggregate experience for the various forms in calculating rates and loss ratios.

(b) An issuer shall mail any refund or return of premium directly to the insured and may not require or permit delivery by an agent or other representative.

(c) An issuer shall comply with section 1882 (c) (3) of the social security act, 42 U.S.C. 1395ss, by complying with all of the following:

1. Accepting a notice from a Medicare issuer on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice.

2. Notifying the participating physician or supplier and the beneficiary of the payment determination.

3. Paying the participating physician or supplier directly.

4. Furnishing, at the time of enrollment, each insured with a card listing the policy or certificate name, number and a central mailing address to which notices from a Medicare issuer may be sent.

5. Paying user fees for claim notices that are transmitted electronically or otherwise.

6. Providing to the secretary, at least annually, a central mailing address to which all claims may be sent by Medicare issuers.

7. Certifying compliance with the requirements set forth in this subsection on the Medicare supplement insurance experience reporting form.

(d) 1. Except as provided in subd. 2., an issuer shall continue to make available for purchase any policy or certificate form issued after December 31, 2019, that has been approved by the commissioner. A policy or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

2. An issuer may discontinue the availability of a policy or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy or certificate form in this state.

3. An issuer that discontinues the availability of a policy or certificate form pursuant to subd. 2., shall not file for approval a new policy or certificate form of the same type, as defined at subd. (3) (zar), as the discontinued form for a period of 5 years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

4. This subsection shall not apply to the riders permitted in sub. (5t) (e).

(e) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(f) A change in the rating structure or methodology shall be considered a discontinuance under par. (d) 1., unless the issuer complies with the following requirements:

1. The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

2. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

(g) Except as provided in par. (h), the experience of all policy or certificate forms of the same type, as defined in sub. (3) (zar), in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in sub. (31).

(h) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(i) No issuer may issue a Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy to an applicant 75 years of age or older, unless the applicant is subject to sub. (3r) or, prior to issuing coverage, the issuer either agrees not to rescind or void the policy or certificate except for intentional fraud in the application, or obtains one of the following:

1. A copy of a physical examination.

2. An assessment of functional capacity.

3. An attending physician's statement.

4. Copies of medical records.

(j) Notwithstanding par. (a), an issuer may file and use only one individual Medicare select policy form and one group Medicare select certificate form. These policy or certificate forms shall not be aggregated with non-Medicare select forms in calculating premium rates, loss ratios and premium refunds.

(k) If an issuer nonrenews an insured who has a nonguaranteed renewable Medicare supplement policy or certificate with the issuer, the issuer shall at the time any notice of nonrenewal is sent to the insured, offer a currently available individual replacement Medicare supplement policy or certificate and those currently available riders resulting in coverage substantially similar to coverage provided by the replaced policy or certificate without underwriting. This replacement shall comply with sub. (27).

(L) For policies or certificates issued to persons newly eligible for Medicare on or after January 1, 2020, issuers shall combine the Wisconsin experience of all policy or certificate forms of the same type, as defined at sub. (3) (zar), for the purpose of calculating the loss ratio under sub. (16) (d), and rates. The rates for all policies or certificates of the same type shall be adjusted by the same percentage. If the Wisconsin experience is not credible, then national experience can be considered.

(m) If Medicare determines the eligibility of a covered service, then the issuer shall use Medicare's determination in processing claims.

Section 59. INS 3.39 (15) is amended to read:

INS 3.39 (15) Prior to use in this state, every issuer shall file with the commissioner a copy of any advertisement used in connection with the sale of Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policies issued with an effective date after December 31, 1989. If the advertisement does not reference a particular issuer or Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy ~~or certificate~~, each agent utilizing the advertisement shall file the advertisement with the commissioner ~~on a form specified by the commissioner~~ in the manner compliant with the commissioner's instructions. The advertisements shall comply with all applicable laws and rules of this state, including s. Ins 3.27 (9).

SECTION 60. INS 3.39 (15) (Note) is repealed.

SECTION 61. INS 3.39 (16) (a), (c), and (d) (intro.) and 1. are amended to read:

INS 3.39 (16) (a) Every issuer providing Medicare supplement or Medicare select ~~Medicare cost~~ coverage on a group or individual basis on policies or certificates ~~issued before or after August 1, 1992~~ in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of par. (d) when combined with actual experience to date. Filings of rate revisions shall 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.

(c) As soon as practicable, but ~~no later than October 1 of the year~~ prior to the effective date of enhancements in Medicare benefits, every issuer providing Medicare supplement or Medicare select ~~cost~~ policies or certificates in this state shall file with the commissioner in accordance with the applicable filing procedures of this state appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the current premium for the applicable policies or certificates. Supporting documents as necessary to justify the adjustment shall accompany the filing.

(d) (intro.) For purposes of subs. (4) (e), (4m) (e), (4t) (e), (14) (L), (14m) (L), (14t) (L) and this subsection, the loss ratio standards shall be:

1. At least 65% in the case of individual policies~~.~~;

SECTION 62. INS 3.39 (16) (d) 3. is renumbered INS 3.39 (16) (d) 3. (intro.) and amended to read:

INS 3.39 (16) (d) 3. For existing policies subject to this subsection, the loss ratio shall be calculated on the basis of incurred claims experience or incurred health care expenses where

coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices. Incurred health care expenses when coverage is provided by a health maintenance organization may not include any of the following:

SECTION 63. INS 3.39 (16) (d) 3. a. to g. are created to read:

INS 3.39 (16) (d) 3. a. Home office and overhead costs.

b. Advertising costs.

c. Commissions and other acquisition costs.

d. Taxes.

e. Capital costs.

f. Administrative costs.

g. Claims processing costs.

SECTION 64. INS 3.39 (16) (e), and (17) are amended to read:

INS 3.39 (16) (e) An issuer may not use or change any premium rates for an individual or group Medicare supplement ~~or Medicare cost~~ policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and ~~approved~~ not disapproved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner and in accordance with ~~sub.~~ subs. (4) (g), (4m) (f), and (4t) (f) as applicable.

(17) An issuer may offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards and is filed and approved by the commissioner. The new or innovative benefits may include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available and are cost-effective. New or innovative benefits may not include an outpatient prescription drug benefit. New or innovative benefits may not be used to change or reduce benefits, including a change of any cost-sharing provision. Approval of

new or innovative benefits must not adversely impact the goal of Medicare supplement simplification.

SECTION 65. INS 3.39 (21) (a) is amended to read:

INS 3.39 (21) (a) An issuer may provide and an agent or other representative may accept commission or other compensation for the sale of a Medicare supplement policy or certificate, or Medicare ~~cost~~ select policy or certificate only if the first year commission or other first year compensation is ~~at least 100% and no more than 150%~~ no more than 200% of the commission or other compensation paid for selling or servicing the policy or certificate in the 2nd year.

SECTION 66. INS 3.39 (21) (f) is created to read:

INS 3.39 (21) (f) No issuer may provide an agent or other representative commission or compensation for the sale of any other Medicare supplement policy or certificate, or Medicare select policy or certificate to an individual who is eligible for guaranteed issue under sub. (34), calculated on a different basis of the commissions paid for the sale of a Medicare supplement policy or certificate, or Medicare select policy or certificate to an individual who is eligible for open enrollment under sub. (3r).

SECTION 67. INS 3.39 (22) (d), (f) (intro.) and 1., (23) (a) (intro.), (c) and (e), and (24) (a) (intro.) and 3. are amended to read:

INS 3.39 (22) (d) If a Medicare supplement ~~or Medicare cost~~ policy or certificate, Medicare select policy or certificate contains any limitations with respect to ~~pre-existing~~ preexisting conditions, such limitations ~~shall~~ may appear on the first page~~.~~ or as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(f) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement, Medicare select, or Medicare cost ~~insurance~~ policies or certificates in the format similar to Appendix 4, Appendix 4m, or Appendix 4t. The notice shall contain all of the following:

1. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy ~~or certificate,~~; and

(23) (a) Application forms for a Medicare supplement policy or certificate, a Medicare select policy or certificate, and a Medicare cost ~~coverage~~ policy shall comply with all relevant statutes and rules. The application form, or a supplementary form signed by the applicant and agent, shall include the following statements and questions:

(c) Upon determining that a sale will involve replacement, an issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement, Medicare select policy or certificate, or Medicare cost policy ~~or certificate~~, a notice regarding the replacement of ~~accident and sickness~~ Medicare supplement coverage in no less than 12 point type. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the solicitation of the policy the notice regarding replacement of ~~accident and sickness~~ Medicare supplement coverage.

(e) If the application contains questions regarding health and tobacco usage, include a statement that health questions should not be answered if the applicant is in the open-enrollment period described in sub. ~~(4m)~~(3r), or during a guaranteed issue period under sub. (34).

(24) (a) Every issuer marketing Medicare supplement insurance coverage in this state, directly or through its producers, shall do all of the following:

3. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or ~~enrollee~~ insured for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

SECTION 68. INS 3.39 (24) (a) 4. is created to read:

INS 3.39 (24) (a) 4. Display prominently by type-size, stamp or other appropriate means, on the first page of the policy the following: **"Notice to buyer: This policy may not cover all of your medical expenses."**

SECTION 69. INS 3.39 (25) (a), (b), and (c), and (26) (a) (intro.) and 1. are amended to read:

INS 3.39 (25) (a) In recommending the purchase or replacement of any Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare ~~replacement~~ cost policy ~~or certificate~~, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) Any sale of Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare ~~replacement~~ cost policy ~~or certificate~~ that will provide an individual more than one Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare ~~replacement~~ cost policy ~~or certificate~~ is prohibited.

(c) An agent shall forward each application taken for a Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare ~~replacement~~ cost policy to the issuer within 7 calendar days after taking the application. An agent shall mail the portion of any premium collected due the issuer to the issuer within 7 days after receiving the premium.

(26) (a) On or before March 1 of each year, every issuer providing Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost ~~insurance coverage~~ policy in this state shall report the following information for every individual resident of this state for which the insurer has in force more than one Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost ~~insurance~~ policy ~~or certificate~~:

1. Policy and certificate number~~, and~~.

SECTION 70. INS 3.39 (26) (a) 3. to 6. are created to read:

INS 3.39 (26) (a) 3. Type of policy.

4. Company name and national association of insurance commissioners number.

5. Name and contact information of person completing the form.

6. Other information as requested by the commissioner.

SECTION 71. INS 3.39 (26) (b), (27), (28) (title), (a) (intro.), (b) 2., and (c), (29) (a) and (b) 1., and (30) (a) are amended to read:

INS 3.39 (26) (b) The items in par. (a) must be grouped by individual policyholder or certificateholder and listed on a form ~~in substantially the same format as~~ made available by the commissioner. ~~Appendix 9~~ Issuers shall submit the information in the manner compliant with the commissioner's instructions on or before March 1 of each year.

(27) If a Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy ~~or certificate~~ replaces another Medicare supplement policy or certificate, Medicare select policy or certificate or Medicare cost policy ~~or certificate~~ that has been in effect for at least 6 months, the replacing issuer shall waive any time periods applicable to ~~pre-existing condition~~ preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement, Medicare select, or new Medicare cost policy for similar benefits to the extent such ~~time was~~ periods were satisfied under the original policy or certificate.

(28) GROUP ~~POLICY~~ CERTIFICATE CONTINUATION AND CONVERSION REQUIREMENTS. **(a)** If a group Medicare supplement ~~insurance policy~~ certificate is terminated by the group ~~policyholder~~ issued a certificate and not replaced as provided in par. (c), the issuer shall offer certificateholders at least the following choices:

(b) 2. At the option of the group ~~policyholder~~ issued a certificate, offer the certificateholder continuations of coverage under the group ~~policy~~ certificate for the time specified in s. 632.897, Stats.

(c) If a group Medicare supplement ~~policy~~ certificate is replaced by another group Medicare supplement ~~policy~~ certificate, the issuer of the replacement ~~policy~~ certificate shall offer coverage to all persons covered under the old group ~~policy~~ certificate on its date of termination. Coverage under the new group ~~policy~~ certificate shall not result in any ~~limitation~~ exclusion for ~~pre-~~

~~existing~~ preexisting conditions that would have been covered under the group ~~policy~~ certificate being replaced.

(29) FILING AND APPROVAL REQUIREMENTS. **(a)** An issuer shall not deliver or issue for delivery a Medicare supplement policy or certificate, Medicare select policy or certificate or Medicare cost policy to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

(b) 1. Beginning January 1, 2007, issuers shall replace existing amended policies and riders for current and renewing ~~enrollees~~ insureds with filed and approved policy or certificate forms that are compliant with the MMA. An issuer shall, beginning January 1, 2007, use filed and approved policy or certificate forms that are compliant with the MMA for all new business.

(30) (a) 1. This subsection shall apply only to Medicare select policies and certificates issued to persons first eligible for Medicare prior to June 1, 2010. This subsection does not apply to Medicare supplement policies and certificates or Medicare cost policies.

2. No Medicare select policy or certificate may be advertised as a Medicare select policy or certificate unless it meets the requires of this subsection.

SECTION 72. INS 3.39 (30) (b) is repealed.

SECTION 73. INS 3.39 (30) (k) (intro.), (n) (intro.), (q) 12., (r) 12., and (30m) (a) 1. are amended to read:

INS 3.39 (30) (k) A Medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from its subscribers for Wisconsin mandated benefits. ~~Such~~ The grievance procedures shall be aimed at mutual agreement for settlement ~~and~~, may include arbitration procedures, and may include all of the following~~.~~:

(n) Medicare select policies and certificates shall provide for continuation of coverage in the event the ~~Secretary~~ secretary determines that Medicare select policies and certificates issued

pursuant to this section should be discontinued due to either the failure of the Medicare select federal program to be reauthorized under law or its substantial amendment.

(q) 12. Coverage of 100% of all cost sharing under Medicare Part A or B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the ~~Secretary~~ secretary.

(r) 12. Coverage for 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $2,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the ~~Secretary~~ secretary.

(30m) (a) 1. This subsection shall only apply to Medicare select policies and certificates issued to persons first eligible for Medicare on or after June 1, 2010 and prior to January 1, 2020. This subsection does not apply to Medicare supplement policies or certificates.

SECTION 74. INS 3.39 (30m) (b) is repealed.

SECTION 75. INS 3.39 (30m) (i) 1. (intro.), and 8., (k) (intro.), (n) (intro.), (q) (intro.), (r) 12., and (s) 12. are amended to read:

INS 3.39 (30m) (i) 1. An outline of coverage in substantially the same format as Appendices ~~2~~2m and ~~5~~5m sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate to the following:

8. A designation: MEDICARE SELECT POLICY. This designation shall be immediately below and in the same type size as the designation required in sub. ~~(4s)~~(4m) (a) 10.

(k) A Medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from its subscribers for Wisconsin mandated benefits. ~~Such~~ The grievance procedures shall be aimed at mutual agreement for settlement ~~and~~, may include arbitration procedures, and include all of the following~~.~~:

(n) Medicare select policies and certificates shall provide for continuation of coverage in the event the ~~Secretary~~ secretary determines that Medicare select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare select federal program to be reauthorized under law or its substantial amendment, then the following apply:

(q) Permissible additional coverage may only be added to the policy or certificate as separate riders. The issuer shall issue a separate rider for each additional coverage offered. Issuers shall ensure that the riders offered are compliant with MMA, each rider is priced separately, available for purchase separately at any time, subject to underwriting and the preexisting limitation allowed in sub. ~~(4s)~~(4m) (a) 2., and may consist of the following:

(r) 12. Coverage for 100% of all cost sharing under Medicare Part A or B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of [$4,440] in 2010, indexed each year by the appropriate inflation adjustment specified by the ~~Secretary~~ secretary.

(s) 12. Coverage for 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of [$2,220] in 2010, indexed each year by the appropriate inflation adjustment specified by the ~~Secretary~~ secretary.

SECTION 76. INS 3.39 (30t) is created to read:

INS 3.39 (30t) MEDICARE SELECT POLICIES AND CERTIFICATES. **(a)** 1. This subsection shall apply only to Medicare select policies and certificates issued to persons newly eligible for Medicare on or after January 1, 2020. This subsection does not apply to Medicare supplement policies or certificates or to Medicare cost policies.

2. No Medicare select policy or certificate may be advertised as a Medicare select policy or certificate unless it meets the requirements of this subsection.

(c) The commissioner may authorize an issuer to offer a Medicare select policy or certificate, pursuant to this subsection OBRA, if the commissioner finds that the issuer has satisfied all of the requirements of this subsection.

(d) A Medicare select issuer may not issue a Medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner.

(e) A Medicare select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least all of the following information:

1. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration of all of the following:

a. That covered services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual medical travel times within the community.

b. That the number of network providers in the service area is sufficient, with respect to current and expected policyholders or certificateholders, either to deliver adequately all services that are subject to a restricted network provision or to make appropriate referrals.

c. That there are written agreements with network providers describing specific responsibilities.

d. Emergency care is available 24 hours per day and 7 days per week.

e. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare select policy or certificate. This subd. 1. e. may not apply to

supplemental charges, copayment, or coinsurance amounts as stated in the Medicare select policy or certificate.

2. A statement or map providing a clear description of the service area.

3. A description of the grievance procedure to be utilized.

4. A description of the quality assurance program, including all of the following:

a. The formal organizational structure.

b. The written criteria for selection, retention, and removal of network providers.

c. The procedures for evaluating quality of care provided by network providers.

d. The process to initiate corrective action when warranted.

5. A list and description, by specialty, of the network providers.

6. Copies of the written information proposed to be used by the issuer to comply with par. (i).

7. Any other information requested by the commissioner.

(f) 1. A Medicare select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing such changes. Such changes shall be considered approved by the commissioner after 30 days after filing unless specifically disapproved.

2. An updated list of network providers shall be filed with the commissioner at least quarterly.

(g) A Medicare select policy or certificate may not restrict payment for covered services provided by non-network providers if all of the following occur:

1. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition.

2. It is not reasonable to obtain services described in subd. 1. through a network provider.

(h) A Medicare select policy or certificate shall provide payment for full coverage under the policy or certificate for covered services that are not available through network providers.

(i) A Medicare select issuer shall make full and fair disclosure in writing of the provisions, coinsurance, or copayments, restrictions, and limitations of the Medicare select policy or certificate to each applicant. This disclosure shall include at least the following:

1. An outline of coverage in substantially the same format as Appendices 2t and 5t sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate to the following:

a. Other Medicare supplement policies or certificates offered by the issuer.

b. Other Medicare select policies or certificates.

2. A description, including address, phone number and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

3. A description of the restricted network provisions, including payments for copayments or coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in the Medicare Select 50% and 25% Coverage Cost-Sharing plans offered by the Medicare select issuer under pars. (r) and (s).

4. A description of coverage for emergency and urgently needed care and other out of service area coverage.

5. A description of limitations on referrals to restricted network providers and to other providers.

6. A description of the policyholder's or certificateholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

7. A description of the Medicare select issuer's quality assurance program and grievance procedure.

8. A designation: **MEDICARE SELECT POLICY**. This designation shall be immediately below and in the same type size as the designation required in sub. (4t) (a) 10.

9. The caption, except that the word “certificate" may be used instead of “policy," if appropriate: “The Wisconsin Insurance Commissioner has set standards for Medicare select policies. This policy meets these standards. It, along with Medicare, may not cover all of your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see ‘Wisconsin Guide to Health Insurance for People with Medicare,’ given to you when you applied for this policy. Do not buy this policy if you did not get this guide."

(j) Prior to the sale of a Medicare select policy or certificate, a Medicare select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to par. (i) and that the applicant understands the restrictions of the Medicare select policy or certificate.

(k) A Medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from its subscribers for Wisconsin mandated benefits. These grievance procedures shall be aimed at mutual agreement for settlement, may include arbitration procedures, and may include all of the following:

1. The grievance procedure shall be described in the policy and certificate and in the outline of coverage.

2. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder or certificateholder describing how a grievance may be registered with the issuer.

3. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

4. If a grievance is found to be valid, corrective action shall be taken promptly.

5. All concerned parties shall be notified about the results of a grievance.

6. The issuer shall report to the commissioner no later than each March 31st regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

(L) At the time of initial purchase of a Medicare select policy or certificate, a Medicare select issuer shall make available to each applicant for the policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(m) 1. At the request of an individual insured under a Medicare select policy or certificate, a Medicare select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer, that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make Medicare select policies or certificates available without requiring evidence of insurability after the Medicare select policy or certificate has been in force for 6 months.

2. For the purposes of this subdivision, a Medicare supplement policy or certificate shall be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Medicare Part B excess charges.

(n) Medicare select policies and certificates shall provide for continuation of coverage in the event the secretary determines that Medicare select policies and certificates issued under this section should be discontinued due to either the failure of the Medicare select program to be reauthorized under law or its substantial amendment, then all of the following apply:

1. Each Medicare select issuer shall make available to each individual insured under a Medicare select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer, which has comparable or lesser benefits and which does not

contain a restricted network provision. The issuer shall make Medicare supplement policies and certificates available without requiring evidence of insurability.

2. For the purposes of this subdivision, a Medicare supplement policy or certificate shall be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at–home recovery services or coverage for Medicare Part B excess charges.

(o) A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the CMS, for the purpose of evaluating the Medicare select program.

(p) Except as provided in par. (r) or (s), a Medicare select policy or certificate issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, shall contain the following coverages:

1. The "basic Medicare supplement coverage" as described in sub. (5t) (d).

2. Coverage for 100% of the Medicare Part A hospital deductible as described in sub. (5t) (e) 1.

3. Coverage for home health care for an aggregate of 365 visits per policy or certificate year as described in sub. (5t) (e) 3.

4. Coverage for preventive health care services as described in sub. (5t) (d) 15.

5. Coverage for emergency care obtained outside of the United States as described in sub. (5t) (e) 6.

(q) Permissible additional coverage may only be added to the policy or certificate as separate riders. The issuer shall issue a separate rider for each additional rider offered. Issuers shall ensure that the riders offered are compliant with MMA, each rider is priced separately, available for purchase separately at any time, subject to underwriting and the preexisting limitation allowed in sub. (4t) (a) 2., and may consist of any of the following:

1. Coverage for 50% of the Medicare Part A hospital deductible with no out-of-pocket maximum as described in sub. (5t) (e) 2.

2. Coverage for Medicare Part B copayment or coinsurance as described in sub. (5t) (e) 4.

(r) The Medicare Select 50% Cost-Sharing plans issued to persons who first became eligible for Medicare on or after January 1, 2020, shall only contain the following coverages:

1. The designation: **MEDICARE SELECT 50% COST-SHARING PLAN.**

2. Coverage for 100% of the Medicare Part A hospital coinsurance or copayment amount for each day used from the 61st through the 90th day in any Medicare benefit period.

3. Coverage for 100% of the Medicare Part A hospital coinsurance or copayment amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period.

4. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage for 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime limitation benefit of an additional 365 days.

5. Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation as described in subd. 12. is met.

6. Coverage for 50% of the coinsurance or copayment amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation as described in subd. 12. is met.

7. Coverage for 50% of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation as described in subd. 12. is met.

8. Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal

regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation as described in subd. 12. is met.

9. Except for coverage provided in subd. 11., coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder or certificateholder pays the Medicare Part B deductible until the out-of-pocket limitation as described in subd. 12. is met.

10. Coverage for 100% of the cost sharing for the benefits described in sub. (5t) (d) 1., 6., 7., 9., 14., 16., and 17., and (e) 3., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder or certificateholder pays the Medicare Part A and B deductible and the out-of-pocket limitation described in subd. 12. is met.

11. Coverage for 100% of the cost sharing for Medicare Part B preventive services after the policyholder or certificateholder pays the Medicare Part B deductible.

12. Coverage for 100% of all cost sharing under Medicare Part A or B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B indexed each year by the appropriate inflation adjustment specified by the secretary.

(s) The Medicare Select 25% Coverage Cost-Sharing plans issued to persons who first became eligible for Medicare on or after January 1, 2020, shall only contain all of the following phrases and coverages:

1. The designation: **MEDICARE SELECT 25% COST-SHARING PLAN**.

2. Coverage for 100% of the Medicare Part A hospital coinsurance or copayment amount for each day used from the 61st through the 90th day in any Medicare benefit period.

3. Coverage for 100% of the Medicare Part A hospital coinsurance or copayment amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period.

4. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage for 100% of the Medicare Part A eligible expenses for hospitalization paid

at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime limitation benefit of an additional 365 days.

5. Coverage for 75% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation as described in subd. 12. is met.

6. Coverage for 75% of the coinsurance or copayment amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation as described in subd. 12. is met.

7. Coverage for 75% of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation as described in subd. 12. is met.

8. Coverage for 75%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation as described in subd. 12. is met.

9. Except for coverage provided in subd. 11., coverage for 75% of the cost sharing otherwise applicable under Medicare Part B, except there shall be no coverage for the Medicare Part B deductible until the out-of-pocket limitation as described in subd. 12. is met.

10. Coverage for 100% of the cost sharing for the benefits described in sub. (5t) (d) 1., 6., 7., 9., 14., 16., and 17., and (e) 3., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder or certificateholder pays the Medicare Part A and B deductible and the out-of-pocket limitation described in subd. 12. is met.

11. Coverage for 100% of the cost sharing for Medicare Part B preventive services after the policyholder or certificateholder pays the Medicare Part B deductible.

12. Coverage for 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual

expenditures under Medicare Parts A and B, indexed each year by the appropriate inflation adjustment specified by the secretary.

(t) A Medicare select policy or certificate may include permissible additional coverage as described in sub. (5t) (e) 2., 4., and 6. These riders, if offered, shall be added to the policy or certificate as separate riders or amendments and shall be priced separately and available for purchase separately.

(u) Issuers writing Medicare select policies or certificates shall additionally comply with subchs. I and III of ch. INS 9.

SECTION 77. INS 3.39 (31) (a) and (b) is repealed and recreated to read:

INS 3.39 (31) (a) Every issuer providing individual or group Medicare supplement policies or certificates and every issuer providing individual or group Medicare select policies or certificates shall collect and file the following information with the commissioner. The data must be provided on a form made available by the commissioner. Issuers shall submit the following information in the manner compliant with the commissioner's instructions on or before May 31 of each year:

1. The actual experience loss ratio of incurred claims to earned premium net of refunds.

2. A credibility adjustment based on a creditability factor:

3. A comparison to the benchmark loss ratio that is a cumulative incurred claims divided by the cumulative earned premiums to date.

4. A calculation of the amount of refund or premium credit, if any.

5. A certification that the refund calculation is accurate.

(b) 1. For policies or certificates issued between December 31, 1980, and January 1, 1992, issuers shall combine the Wisconsin experience of all policy or certificate forms of the same type, as defined at sub. (3) (zar), for purposes of calculating the amount of refund or premium credit, if any. Issuers may combine the Wisconsin experience of all policies issued prior to January 1, 1981, with those issued between December 31, 1980, and January 1, 1992, if the

issuer uses the 60% loss ratio for individual policies and the 70% loss ratio for group certificates renewed prior to January 1, 1996, and the appropriate loss ratios specified in sub. (16) (d), thereafter.

2. For policies or certificates issued on or after January 1, 1992, and prior to June 1, 2010, issuers shall combine the Wisconsin experience of all policy or certificate forms of the same type, as defined at sub. (3) (zar), for the purposes of calculating the amount of the refund or premium credit, if any, if the issuer uses the 65% loss ratio for individual policies and the 75% loss ratio for group certificates renewed on or after January 1, 1996 and prior to June 1, 2010, and the appropriate loss ratios specified in sub. (16) (d).

SECTION 78. INS 3.39 (31) (bm) is repealed.

SECTION 79. INS 3.39 (34) (a) 1., 2., (b) (intro.), 1s. and 2., (e) 4. and 5. are amended to read:

INS 3.39 (34) (a) 1. ~~Eligible persons~~ Persons eligible for guarantee issue are those individuals described in par. (b) who seek to enroll under the policy during the period specified in par. (c), and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy, Medicare select policy or Medicare cost policy, and where applicable, evidence of enrollment in Medicare Part D.

2. With respect to an eligible person, an issuer may not deny or condition the issuance or effectiveness of a Medicare supplement policy, Medicare select policy, or Medicare cost policy described in par. (e) that is offered and is available for issuance to new enrollees by the issuer, and shall not discriminate in the pricing of such a Medicare supplement, Medicare select, or Medicare cost policy because of health status, claims experience, receipt of health care, or medical condition and ~~shall not impose an exclusion of benefits based on condition and~~ shall not impose an exclusion of benefits based on a ~~pre-existing~~ preexisting condition under such a Medicare supplement policy, Medicare select policy, or Medicare cost policy.

(b) *Eligible persons.* An eligible person for guarantee issue is an individual described in any of the following subdivisions:

1s. The individual is enrolled in a Medicare select ~~plan~~ policy and is notified by the issuer, as required in par (f) 3. and s. Ins 9.35, as applicable, that a hospital is leaving the Medicare select policy network and that there is no other ~~participating~~ network provider hospital within a 30 minute or 30 mile radius of the policyholder.

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

(e) 4. Paragraph (b) 7., is a Medicare supplement policy as described in sub. (5) ~~along~~ with any riders available or a Medicare select policy as ~~defined~~ described in sub. (30), that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy or Medicare select policy ~~with~~ containing the outpatient prescription drug coverage.

5. Paragraph (b) 3., is a Medicare cost policy as described in sub. (7) ~~along~~ with any enhancements and riders, that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare cost policy.

SECTION 80. INS 3.39 (34) (ez) is renumbered INS 3.39 (34) (em) and amended to read:

INS 3.39 (34) (em) *Products ~~to which~~ that persons eligible for ~~Medicare persons are entitled~~ guarantee issue on or after June 1, 2010, and prior to January 1, 2020, are entitled to enroll into.* The Medicare supplement policy or certificate, Medicare select policy or certificate, or

Medicare cost policy ~~or certificate to which~~ that the guarantee issue eligible persons are entitled to enroll include any of the following ~~under~~:

1. Paragraph (b) 1., 1m., 1r., 1s., 2., 3. and 4. is a Medicare supplement policy or certificate as ~~defined~~ described in sub. (5m) ~~along~~ with any riders available or a Medicare select policy or certificate as ~~defined~~ described in sub. (30m).

2. Paragraph (b) 5. is the same Medicare supplement policy or certificate in which the individual was most recently ~~previously~~ enrolled, if available from the same issuer, or, if not so available, a policy or certificate as described in subd. 1.

3. Paragraph (b) 6. and 8. is a Medicare supplement policy or certificate as described in sub. (5m) ~~along~~ with any riders available or a Medicare select policy or certificate as defined in sub. (30m).

4. Paragraph (b) 7. is a Medicare supplement policy or certificate as described in sub. (5m) ~~along~~ with any riders available or a Medicare select policy or certificate as ~~defined~~ described in sub. (30m), that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy or certificate.

SECTION 81. INS 3.39 (34) (et) is created to read:

INS 3.39 (34) (et) *Products that persons eligible for guarantee issue are entitled to enroll into who first became eligible for Medicare on or after January 1, 2020.* The Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy that persons are entitled to enroll on the basis of guarantee issue includes any of the following:

1. Paragraph (b) 1., 1m., 1r., 1s., 2., 3. and 4., is a Medicare supplement policy or certificate as described in sub. (5t) with any riders available or a Medicare select policy or certificate as described in sub. (30t).

2. Paragraph (b) 5. is the same Medicare supplement policy or certificate in which the individual was most recently enrolled, if available from the same issuer, or, if not so available, a policy or certificate as described in subd. 1.

3. Paragraph (b) 6. and 8., is a Medicare supplement policy or certificate as described in sub. (5t) with any riders available or a Medicare select policy or certificate as described in sub. (30t).

4. Paragraph (b) 7., is a Medicare supplement policy or certificate as described in sub. (5t) with any riders available or a Medicare select policy or certificate as described in sub. (30t), that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy or certificate.

SECTION 82. INS 3.39 (34) (f) 1. and 2. are amended to read:

INS 3.39 (34) (f) *Notification provisions.* 1. At the time of an event described in par. (b) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies and certificates, Medicare select policies or certificates, or Medicare cost policies under par. (a). The notice shall be communicated within 10 working days of the issuer receiving notification of disenrollment.

2. At the time of an event described in par. (b) of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the (30) (k) the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies or certificates, Medicare select policies or certificates or Medicare cost polices under par. (a). ~~Such~~ The notice shall be communicated within 10 working days of the issuer receiving notification of disenrollment.

SECTION 83. INS 3.39 (35) (intro.) and (a) are amended to read:

INS 3.39 (35) EXCHANGE OF MEDICARE SUPPLEMENT POLICY. An issuer that submits and receives approval to offer a Medicare supplement ~~insurance~~ policy or certificate that is effective or issued to persons first eligible for Medicare on or after June 1, 2010, and before June 1, 2011, may offer an exchange subject to the following requirements:

(a) By or before May 31, 2011, on a one-time basis in writing, an issuer may offer to all of its existing Medicare supplement policyholders or certificateholders covered by a policy with an effective prior to June 1, 2010, the option to exchange the existing policy to a different policy that complies with subs. ~~(4s)~~ (4m), (5m) and (30m), as applicable.

SECTION 84. INS 3.39 Appendix 1 is amended to read:

INS 3.39 APPENDIX 1

For policies with an effective date prior to June 1, 2010 the following information shall be inserted prior to each outline of coverage provided to an insured and include the information specific to the plan type.

PREMIUM INFORMATION

We can only raise your premium if we raise the premium for all policies like yours in this state. [Include information specifying when premiums will change.]

If your policy was issued as an under age 65 policy due to disability, when you turn 65 premiums will remain at the disabled rates. [Include this statement within premium information when issuer does not change premium to age 65 rate.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to (insert issuer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments directly to you.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

(1) The outline of coverage for a Medicare ~~replacement insurance~~ cost policy as ~~defined~~ described in s. 600.03 (28p) a. and c., Stats., shall contain the following language: Medicare ~~replacement insurance~~ cost policy: This policy provides basic Medicare hospital and physician benefits. It also includes benefits beyond

those provided by Medicare. This policy is a replacement for Medicare and is subject to certain limitations in choice of providers and area of service. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.

(2) (a) In 24–point type: For Medicare supplement policies marketed by intermediaries:

Neither (insert company's name) nor its agents are connected with Medicare.

(b) In 24–point type: For Medicare supplement and Medicare select policies marketed by direct response:

(insert company's name) is not connected with Medicare.

(c) For Medicare ~~replacement~~ cost policies as ~~defined~~ described in s. 600.03 (28p) a. and c., Stats.:

(insert company's name) has contracted with Medicare to provide Medicare benefits. Except for emergency care anywhere or urgently needed care when you are temporarily out of the service area, all services, including all Medicare services, must be provided or authorized by (insert company's name).

(3) (a) For Medicare supplement policies, provide a brief summary of the major benefits and gaps in Medicare Parts A and B with a parallel description of supplemental benefits, including dollar amounts, as outlined in these charts.

(b) For Medicare ~~replacement~~ cost policies, as ~~defined~~ described in s. 600.03 (28p) a. and c., Stats., provide a brief summary of both the basic Medicare benefits in the policy and additional benefits using the basic format as outlined in these charts and modified to accurately reflect the benefits.

(c) If the coverage is provided by a health maintenance organization as defined in s. 609.01 (2), Stats., provide a brief summary of the coverage for emergency care anywhere and urgent care received outside the service area if this care is treated differently than other covered benefits.

(4) If the plan is a Medicare Supplement High Deductible Plan as ~~defined~~ described in sub. (5) (n) or (o), add the following text in a bold or contrasting color: You will pay [half (for plans ~~defined~~ described in sub. (5) (n))] [one quarter (for plans ~~defined~~ described in sub. (5) (o))] of the cost-sharing of some covered services until you reach the annual out-of-pocket maximum of [$4,000 (for plans ~~defined~~ described in sub. (5) (n))] [$2,000 (for plan ~~defined~~ described in sub. (5) (o))] each calendar year. The amounts you must pay are noted in the chart below. Once you reach the annual limit, the plan pays for 100% for the items or services noted in the chart.

The following information shall be inserted AFTER the specific plan type, Medicare supplement, Medicare supplement cost-sharing, Medicare cost, or Medicare select, outline of coverage that is provided to all insureds. The information shall include the information specific to the plan type.

(5) All limitations and exclusions, including each of the following, must be listed under the caption "**LIMITATIONS AND EXCLUSIONS**" if benefits are not provided:

(a) Nursing home care costs beyond what is covered by Medicare and the additional 30–day skilled nursing mandated by s. 632.895 (3), Stats.

(b) Home health care above the number of visits covered by Medicare and the 365 visits mandated by s. 632.895 (2), Stats. [For Medicare select policies only.]

(c) Physician charges above Medicare's approved charge.

(d) Outpatient prescription drugs.

(e) Most care received outside of U.S.A.

(f) Dental care, dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids, unless eligible under Medicare.

(g) Coverage for emergency care anywhere or for care received outside the service area if this care is treated differently than other covered benefits.

(h) Waiting period for pre–existing conditions.

(i) Limitations on the choice of providers or the geographical area served (if applicable for Medicare select policies only).

(j) Usual, customary, and reasonable limitations.

(6) CONSPICUOUS STATEMENTS AS FOLLOWS:

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

(7) A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.

(8) Information on how to file a claim for services received from non–participating providers because of an emergency within or outside of the service area shall be prominently disclosed.

(9) If there are restrictions on the choice of providers, a list of providers available to enrollees shall be included with the outline of coverage.

(10) ~~A description of the review and appeal procedure for denied claims~~ The definition of grievance as contained in s. Ins 18.01 (4).

(11) The premium for the policy and riders, if any, in the following format:

MEDICARE SUPPLEMENT, MEDICARE SELECT AND MEDICARE COST PREMIUM INFORMATION

Annual Premium

$ ( ) BASIC MEDICARE SUPPLEMENT, MEDICARE SELECT, OR MEDICARE COST COVERAGE

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT, MEDICARE SELECT, OR MEDICARE COST POLICY

Each of these riders may be purchased separately.

(Note: Only optional coverages provided by rider shall be listed here.)

$ ( ) 1. Medicare Part A deductible

100% of Medicare Part A deductible

$ ( ) 2. Additional home health care

An aggregate of 365 visits per year including those covered by Medicare

$ ( ) 3. Medicare Part B deductible

100% of Medicare Part B deductible

$ ( ) 4. Medicare Part B excess charges

Difference between the Medicare eligible charge and the amount charged by the provider which shall be no greater than the actual charge or the limited charge allowed by Medicare, whichever is less

$ ( ) 5. Foreign travel rider

After a deductible not greater than $250, covers at least 80% of expenses associated with emergency medical care received outside the U.S.A. beginning the first 60 days of a trip with a lifetime maximum of at least $50,000

$ ( ) TOTAL FOR BASIC POLICY AND SELECTED OPTIONAL BENEFITS

(Note: The soliciting agent shall enter the appropriate premium amounts and the total at the time this outline is given to the applicant. Medicare select policies and the Medicare Supplement 50% and 25% Cost-Sharing plans and Medicare Select 50% and 25% Cost-Sharing plans shall modify the outline to reflect the benefits that are contained in the policy and the optional or included riders.)

IN ADDITION TO THIS OUTLINE OF COVERAGE, [ISSUER] WILL SEND AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES WITH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

(12) If premiums for each rating classification are not listed in the outline of coverage under subsection (11), then the issuer shall give a separate schedule of premiums for each rating classification with the outline of coverage.

(13) Include a summary of or reference to the coverage required by applicable statutes.

(14) The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate.

Issuers shall select the appropriate outline of coverage specific to the type of plan being presented, Medicare supplement, Medicare supplement cost-sharing, Medicare cost, or Medicare select, from among the following Outlines of Coverage A through D, respectively.

SECTION 85. INS 3.39 Appendix 2 is renumbered INS 3.39 Appendix 2m and amended to read:

INS 3.39 APPENDIX ~~2~~ 2m

For policies ~~with an effective date~~ issued to persons first eligible for Medicare on or after June 1, 2010, and prior to January 1, 2020, the following information shall be inserted prior to each outline of coverage provided to an insured and include the information specific to the plan type.

PREMIUM INFORMATION

We can only raise your premium if we raise the premium for all policies like yours in this state. [Include information specifying when premiums will change.]

If your policy was issued as an under age 65 policy due to disability, when you turn 65 premiums will remain at the disabled rates. [Include this statement within premium information when issuer does not change premium to age 65 rate.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to (insert issuer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments directly to you.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

(1) The outline of coverage for a Medicare ~~replacement~~ cost insurance policy as ~~defined~~ described in s. 600.03 (28p) (a) and (c), Stats., shall contain the following language: Medicare ~~replacement~~ cost insurance policy: This policy provides basic Medicare hospital and physician benefits. It also includes benefits beyond those provided by Medicare. This policy is a replacement for Medicare and is subject to certain limitations in choice of providers and area of service. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.

(2) (a) In 24–point type: For Medicare supplement policies marketed by intermediaries:

Neither (insert company's name) nor its agents are connected with Medicare.

(b) In 24–point type: For Medicare supplement policies marketed by direct response:

(insert company's name) is not connected with Medicare.

(c) For Medicare ~~replacement~~ cost policies as ~~defined~~ described in s. 600.03 (28p) a. and c., Stats.:

(insert company's name) has contracted with Medicare to provide Medicare benefits. Except for emergency care anywhere or urgently needed care when you are temporarily out of the service area, all services, including all Medicare services, must be provided or authorized by (insert company's name).

(3) (a) For Medicare supplement policies, provide a brief summary of the major benefits and gaps in Medicare Parts A and B with a parallel description of supplemental benefits, including dollar amounts, as outlined in these charts.

(b) For Medicare ~~replacement~~ cost policies, as ~~defined~~ described in s. 600.03 (28p) a. and c., Stats., provide a brief summary of both the basic Medicare benefits in the policy and additional benefits using the basic format as outlined in these charts and modified to reflect accurately the benefits.

(c) If the coverage is provided by a health maintenance organization as defined in s. 609.01 (2), Stats., provide a brief summary of the coverage for emergency care anywhere and urgent care received outside the service area if this care is treated differently than other covered benefits.

The following information shall be inserted AFTER the specific plan type outline of coverage that is provided to all insureds. The information shall include the information specific to the plan type.

(4) All limitations and exclusions, including each of the following, must be listed under the caption "**LIMITATIONS AND EXCLUSIONS**" if benefits are not provided:

(a) Nursing home care costs beyond what is covered by Medicare and the additional 30–day skilled nursing mandated by s. 632.895 (3), Stats.

(b) Home health care above the number of visits covered by Medicare and the 365 visits mandated by s. 632.895 (2), Stats. [For Medicare select policies only.]

(c) Physician charges above Medicare's approved charge.

(d) Outpatient prescription drugs.

(e) Most care received outside of U.S.A.

(f) Dental care, dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids, unless eligible under Medicare.

(g) Coverage for emergency care anywhere or for care received outside the service area if this care is treated differently than other covered benefits.

(h) Waiting period for preexisting conditions.

(i) Limitations on the choice of providers or the geographical area served (if applicable for Medicare select policies only).

(j) Usual, customary, and reasonable limitations.

(5) CONSPICUOUS STATEMENTS AS FOLLOWS:

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

(6) A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.

(7) Information on how to file a claim for services received from non–participating providers because of an emergency within or outside of the service area shall be prominently disclosed.

(8) If there are restrictions on the choice of providers, a list of providers available to insureds shall be included with the outline of coverage.

(9) ~~A description of the review and appeal procedure for denied claims~~ The definition of grievance as contained in s. Ins 18.01 (4).

(10) The premium for the policy and riders, if any, in the following format:

MEDICARE SUPPLEMENT AND MEDICARE SELECT PREMIUM INFORMATION
Annual Premium
$ ( ) BASIC MEDICARE SUPPLEMENT OR MEDICARE SELECT COVERAGE

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT OR MEDICARE SELECT POLICY

Each of these riders may be purchased separately.

(Note: Only optional coverages provided by rider shall be listed here.)

$ ( ) 1. 100% of the Medicare Part A hospital deductible

$ ( ) 2. 50% of the Medicare Part A hospital deductible per benefit period with no out-of-pocket maximum

$ ( ) 3. Additional home health care

An aggregate of 365 visits per year including those covered by Medicare

$ ( ) 4.100% of Medicare Part B deductible

$ ( ) 5. 100% of the Medicare Part B medical coinsurance that is subject to copayment or coinsurance of no more than $20 per office visit and no more than $50 per emergency room visit in addition to the Medicare Part B coinsurance and in addition to out-of-pocket maximums. The emergency room copayment or coinsurance fee shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

$ ( ) 6. Medicare Part B excess charges

Difference between the Medicare eligible charge and the amount charged by the provider that shall be no greater than the actual charge or the limited charge allowed by Medicare, whichever is less

$ ( ) 7. Foreign travel emergency rider

After a deductible not greater than $250, covers at least 80% of expenses associated with emergency medical care received outside the U.S.A. during the first 60 days of a trip with a lifetime maximum of at least $50,000

$ ( ) TOTAL FOR BASIC POLICY AND SELECTED OPTIONAL BENEFITS

(Note: The soliciting agent shall enter the appropriate premium amounts and the total at the time this outline is given to the applicant. Medicare select policies and the Medicare Supplement 50% and 25% Cost-Sharing plans and Medicare Select 50% and 25% Cost-Sharing plans shall modify the outline to reflect the benefits that are contained in the policy or certificate and the optional or included riders.)

IN ADDITION TO THIS OUTLINE OF COVERAGE, [ISSUER] WILL SEND AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES THAT WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

(11) If premiums for each rating classification are not listed in the outline of coverage under subsection (10), then the issuer shall give a separate schedule of premiums for each rating classification with the outline of coverage.

(12) Include a summary of or reference to the coverage required by applicable statutes.

(13) The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate.

SECTION 86. INS 3.39 Appendix 2t is created to read:

INS 3.39 APPENDIX 2t

For policies issued to persons newly eligible for Medicare on or after January 1, 2020, the following information shall be inserted prior to each outline of coverage provided to an insured and include the information specific to the plan type.

PREMIUM INFORMATION

We can only raise your premium if we raise the premium for all policies like yours in this state. [Include information specifying when premiums will change.]

If your policy was issued as an under age 65 policy due to disability, when you turn 65 premiums will remain at the disabled rates. [Include this statement within premium information when issuer does not change premium to age 65 rate.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to (insert issuer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments directly to you.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

(1) The outline of coverage for a Medicare cost insurance policy as described in s. 600.03 (28p) (a) and (c), Stats., shall contain the following language: Medicare cost insurance policy: This policy provides basic Medicare hospital and physician benefits. It also includes benefits beyond those provided by Medicare. This policy is a replacement for Medicare and is subject to certain limitations in choice of providers and area of service. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.

(2) (a) In 24–point type: For Medicare supplement policies marketed by intermediaries:

Neither (insert company's name) nor its agents are connected with Medicare.

(b) In 24–point type: For Medicare supplement policies marketed by direct response:

(insert company's name) is not connected with Medicare.

(c) For Medicare cost policies as described in s. 600.03 (28p) a. and c., Stats.:

(insert company's name) has contracted with Medicare to provide Medicare benefits. Except for emergency care anywhere or urgently needed care when you are temporarily out of the service area, all services, including all Medicare services, must be provided or authorized by (insert company's name).

(3) (a) For Medicare supplement policies, provide a brief summary of the major benefits and gaps in Medicare Parts A and B with a parallel description of supplemental benefits, including dollar amounts, as outlined in these charts.

(b) For Medicare cost policies, provide a brief summary of both the basic Medicare benefits in the policy and additional benefits using the basic format as outlined in these charts and modified to reflect accurately the benefits.

(c) If the coverage is provided by a health maintenance organization as defined in s. 609.01 (2), Stats., provide a brief summary of the coverage for emergency care anywhere and urgent care received outside the service area if this care is treated differently than other covered benefits.

The following information shall be inserted AFTER the specific plan type outline of coverage that is provided to all insureds. The information shall include the information specific to the plan type.

(4) All limitations and exclusions, including each of the following, must be listed under the caption "**LIMITATIONS AND EXCLUSIONS**" if benefits are not provided:

(a) Nursing home care costs beyond what is covered by Medicare and the additional 30–day skilled nursing mandated by s. 632.895 (3), Stats.

(b) Home health care above the number of visits covered by Medicare and the 365 visits mandated by s. 632.895 (2), Stats. [For Medicare select policies only.]

(c) Physician charges above Medicare's approved charge.

(d) Outpatient prescription drugs.

(e) Most care received outside of U.S.A.

(f) Dental care, dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids, unless eligible under Medicare.

(g) Coverage for emergency care anywhere or for care received outside the service area if this care is treated differently than other covered benefits.

(h) Waiting period for preexisting conditions.

(i) Limitations on the choice of providers or the geographical area served (if applicable for Medicare select policies only).

(j) Usual, customary, and reasonable limitations.

(5) CONSPICUOUS STATEMENTS AS FOLLOWS:

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

(6) A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.

(7) Information on how to file a claim for services received from non–participating providers because of an emergency within or outside of the service area shall be prominently disclosed.

(8) If there are restrictions on the choice of providers, a list of providers available to insureds shall be included with the outline of coverage.

(9) The definition of grievance as contained in s. Ins 18.01 (4).

(10) The premium for the policy and riders, if any, in the following format:

MEDICARE SUPPLEMENT AND MEDICARE SELECT PREMIUM INFORMATION
Annual Premium
$ ( ) BASIC MEDICARE SUPPLEMENT OR MEDICARE SELECT COVERAGE

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT OR MEDICARE SELECT POLICY

Each of these riders may be purchased separately.

(Note: Only optional coverages provided by rider shall be listed here.)

$ ( ) 1. 100% of the Medicare Part A hospital deductible

$ ( ) 2. 50% of the Medicare Part A hospital deductible per benefit period with no out-of-pocket maximum

$ ( ) 3. Additional home health care

An aggregate of 365 visits per year including those covered by Medicare

$ ( ) 4. 100% of the Medicare Part B medical coinsurance that is subject to copayment or coinsurance of no more than $20 per office visit and no more than $50 per emergency room visit in addition to the Medicare Part B coinsurance and in addition to out-of-pocket maximums. The emergency room copayment or coinsurance fee shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

$ ( ) 5. Medicare Part B excess charges

Difference between the Medicare eligible charge and the amount charged by the provider that shall be no greater than the actual charge or the limited charge allowed by Medicare, whichever is less

$ ( ) 6. Foreign travel emergency rider

After a deductible not greater than $250, covers at least 80% of expenses associated with emergency medical care received outside the U.S.A. during the first 60 days of a trip with a lifetime maximum of at least $50,000

$ ( ) TOTAL FOR BASIC POLICY AND SELECTED OPTIONAL BENEFITS

(Note: The soliciting agent shall enter the appropriate premium amounts and the total at the time this outline is given to the applicant. Medicare select policies and the Medicare Supplement 50% and 25% Cost-Sharing plans and Medicare Select 50% and 25% Cost-Sharing plans shall modify the outline to reflect the benefits that are contained in the policy or certificate and the optional or included riders.)

IN ADDITION TO THIS OUTLINE OF COVERAGE, [ISSUER] WILL SEND AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES THAT WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

(11) If premiums for each rating classification are not listed in the outline of coverage under subsection (10), then the issuer shall give a separate schedule of premiums for each rating classification with the outline of coverage.

(12) Include a summary of or reference to the coverage required by applicable statutes.

(13) The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate.

SECTION 87. INS 3.39 Appendix 3 is renumbered INS 3.39 Appendix 3m and INS 3.39 Appendix 3m (title) and (subtitle), as renumbered, are amended to read:

INS 3.39 APPENDIX ~~3~~3m (title)

OUTLINE OF COVERAGE

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

(The designation and caption required by sub. ~~(4s)~~(4m) (b) 4.)

SECTION 88. INS 3.39 Appendix 3t is created to read:

INS 3.39 APPENDIX 3t

OUTLINE OF COVERAGE

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

(The designation and caption required by sub. (4t) (b) 4.)

MEDICARE SUPPLEMENT PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Note: This includes the Medicare deductibles for Part A and Part B but does not include [the plan's separate riders deductible.]

Note: Add the following text in a bold or contrasting color if the plan is a Medicare supplement insurance - high deductible plan as described at sub. (5t) (k): This high deductible plan offers benefits after one has paid a calendar year [$2000] deductible. This deductible consists of expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B but does not include the plan's separate foreign travel emergency deductible.

SERVICES	**PER BENEFIT PERIOD**	**MEDICARE PAYS**	**[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS**	**YOU PAY**
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $ [current deductible]	$0 or [V OPTIONAL PART A DEDUCTIBLE RIDER* (for non-high deductible plans)] [V PART A DEDUCTIBLE RIDER* (for high deductible plans)] V OPTIONAL MEDICARE 50% PART A DEDUCTIBLE RIDER***	
	61st to 90th days	All but $ [current amount] per day	$ [current amount] per day	
	91st day and after while using 60 lifetime reserve days	All but $ [current amount] per day	$ [current amount] per day	
	Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses**	
	Beyond the additional 365 days	$0	$0	

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days 21st through 100th day 101st day and after	All approved amounts All but $ [current amount] per day $[0]	$0 Up to $[ ] a day $0	
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	
BLOOD	First 3 pints Additional amounts	$0 100%	First 3 pints $0	
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care	$0 or [ ]% of coinsurance or copayments	

* These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

*** This optional rider may reduce your premium when you pay 50% of Medicare Part A deductible.

MEDICARE SUPPLEMENT POLICIES – PART B BENEFITS

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

Note: Add the following text in a bold or contrasting color if the plan is a Medicare supplement insurance-high deductible plan as described at sub. (5t) (k): This high deductible plan offers benefits after one has paid a calendar year [$2000] deductible. This deductible consists of expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B but does not include the plan's separate foreign travel emergency deductible.

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES Eligible expense for physician's services,	First $[ ] of Medicare approved amounts*	$0	$0	

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
in-patient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	Remainder of Medicare approved amounts	Generally 80%	Generally 20% [V OPTIONAL MEDICARE PART B EXCESS CHARGES RIDER** (for non-high deductible plans)] [V MEDICARE PART B EXCESS CHARGES RIDER** (for high deductible plans)] [V OPTIONAL FOREIGN TRAVEL EMERGENCY RIDER** (non-high deductible plans)] [V FOREIGN TRAVEL EMERGENCY RIDER** (for high-deductible plans)]	
BLOOD	First 3 pints Next $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs [$] 20%	
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	
HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	40 visits or V OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER**	
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA	First $250 each calendar year Remainder of charges	[$0]	$250 80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
[PREVENTIVE MEDICAL CARE BENEFIT— NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.]*	[First $120 each calendar year] [Additional charges]	[$0] [$0]	[$120] [$0] or $[dollar amount]	

* Once you have been billed [$] of Medicare approved amounts for covered services (that are noted with an asterisk), your Medicare Part B deductible will have been met for the calendar year.

** These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

*** This is an optional rider that may decrease your premium when you pay copayments for medical and emergency room visits.

SECTION 89. INS 3.39 Appendix 4 is renumbered INS 3.39 Appendix 4m and INS 3.39 Appendix 4m (title), as renumbered, is amended to read:

INS 3.39 APPENDIX 44m (title)

OUTLINE OF COVERAGE

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

(The designation and caption required by sub. (5m) (g) 1. and (h) 1.)

SECTION 90. INS 3.39 Appendix 4t is created to read:

INS 3.39 APPENDIX 4t

OUTLINE OF COVERAGE

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT 50% and 25% COST-SHARING PLANS

(The designation required by sub. (5t) (g) 1. and (h) 1.)

You will pay [half or one quarter] the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[ ] each calendar year. The amounts that count toward your annual out-of-pocket limit are noted with diamonds (?) in the chart below. Once you reach the annual out-of-pocket limit, the policy plays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare approved amounts (these are called "Excess Charges"). You will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE COST-SHARING PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $ [current deductible]	$[ ] (50% or 75% of Medicare Part A deductible.)	☐
	61st to 90th days	All but $ [current amount] per day	$ [current amount] per day	
	91st day and after while using 60 lifetime reserve days	All but $ [current amount] per day	$ [current amount] per day	
	Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses**	
	Beyond the additional 365 days	$0	$0	
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital	First 20 days	All approved amounts	$0	☐
	21st through 100th day	All but $ [current amount] per day	Up to $[ ] a day	
	101st day and after	$0	$0	
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	
BLOOD	First 3 pints	$0	[50% or 75%]	☐
	Additional amounts	100%	$0	
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care	[50% or 75%] of coinsurance or copayments	☐

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

MEDICARE COST-SHARING POLICIES – PART B BENEFITS

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES Eligible expense for physician's services, in-patient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First $[ ] of Medicare approved amounts* Preventive Benefits for Medicare covered services Remainder of Medicare approved amounts	$0 Generally 75% or more of Medicare approved amounts Generally 80%	$0 Remainder of Medicare approved amounts Generally [10% or 15%]	□ □
BLOOD	First 3 pints Next $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 Generally 80%	[50% or 75%] $0 Generally [10% or 15%]	□ □ □
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	
HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	40 visits or V OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER**	
[PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.]*	[First $120 each calendar year] [Additional charges]**	[$0] [$0]**	[$120] [$0] or $[dollar amount]**	

* Once you have been billed [$] of Medicare approved amounts for covered services (that are noted with an asterisk), your Medicare Part B deductible will have been met for the calendar year.

** These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

SECTION 91. INS 3.39 Appendix 5 is renumbered INS 3.39 Appendix 5m and INS 3.39 Appendix 5m (title), as renumbered, is amended to read:

INS 3.39 APPENDIX ~~5~~5m (title)
OUTLINE OF COVERAGE

SECTION 92. INS 3.39 Appendix 5t is created to read:

INS 3.39 APPENDIX 5t
OUTLINE OF COVERAGE

(COMPANY NAME)

OUTLINE OF MEDICARE SELECT INSURANCE AND MEDICARE SELECT 50% and 25% COST-SHARING PLANS

(The designation and caption required by sub. (30t) (i) 8. and 9., or the designation required by sub. (30t) (r) 1. and (s) 1.)

Note: Add the following text if the policy is a Medicare Select 50% or 25% Cost-Sharing Plan: You will pay [half or one quarter] the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[ ] each calendar year. The amounts that count toward your annual out-of-pocket limit are noted with diamonds (?) in the chart below. Once you reach the annual limit, the policy plays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare approved amounts (these are called "Excess Charges"). You will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE SELECT PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $ [current deductible]	$0 or [ ]% of Medicare Part A deductible	□
	61st to 90th days	All but $ [current amount] per day	$ [current amount] per day	
	91st day and after while using 60 lifetime reserve days	All but $ [current amount] per day	$ [current amount] per day	
	Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses**	
	Beyond the additional 365 days	$0	$0	
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital	First 20 days	All approved amounts	$0	
	21st through 100th day	All but $ [current amount] per day	Up to $[ ] a day	□
	101st day and after	$0	$0	
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	
BLOOD	First 3 pints	$0	[3 pints] or [ ] %	□
	Additional amounts	100%	$0	

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care	$0 or [ ]% of coinsurance or copayments	□

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

MEDICARE SELECT POLICIES – PART B BENEFITS

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES Eligible expense for physician's services, in-patient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First $[ ] of Medicare approved amounts [Preventive Benefits for Medicare covered services**] Remainder of Medicare approved amounts	$0 [Generally [ ]% or more of Medicare approved amounts**] Generally 80%	$0 [Remainder of Medicare approved amounts**] Generally [10% or 15%]	□ □
BLOOD	First 3 pints Next $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 Generally 80%	[ ]% $0 Generally [10% or 15%]	□ □ □
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	
HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	365 visits for medically necessary services	
[PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.]*	[First $120 each calendar year] [Additional charges]**	[$0] [$0]**	[$120] [$0] or $[dollar amount]**	

* Once you have been billed [$] of Medicare approved amounts for covered services (that are noted with an asterisk), your Medicare Part B deductible will have been met for the calendar year.

** NOTE: Issuers should include in the outline of coverage the appropriate preventive benefit based upon whether or not the policy is a cost-sharing policy.

SECTION 93. INS 3.39 Appendix 6 is amended to read:

INS 3.39 APPENDIX 6

[NOTICE OF CHANGE FOR OUTLINE OF COVERAGE]
[FOR APPLICANTS FIRST ELIGIBLE FOR MEDICARE PRIOR TO JUNE 1, 2010.]

(COMPANY NAME)
NOTICE OF CHANGES IN MEDICARE AND YOUR [MEDICARE SUPPLEMENT OR MEDICARE ~~REPLACEMENT~~ COST] COVERAGE – 2____

THE FOLLOWING CHART BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR [MEDICARE SUPPLEMENT OR MEDICARE ~~REPLACEMENT~~ COST] COVERAGE.

PLEASE READ THIS CAREFULLY!

[Note: A brief description of the revisions to Medicare Parts A and B with a parallel description of supplemental benefits with subsequent changes, including dollar amounts, provided by the Medicare supplement or Medicare ~~replacement~~ cost coverage in substantially the following format.]

SERVICES	**MEDICARE BENEFITS**		**YOUR [MEDICARE SUPPLEMENT OR MEDICARE ~~REPLACEMENT~~ COST] COVERAGE**	
	In 2____, Medicare Pays Per Benefit Period	**Effective January 1, 2____, Medicare will Pay**	**In 2____, Your Coverage Pays**	**Effective January 1, 2____, Your Coverage will Pay Per Calendar Year**
MEDICARE PART A SERVICES AND SUPPLIES				
HOSPITALIZATION Inpatient Hospital Services, Semi-Private Room & Board, Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room	All but $___ for the first 60 days/benefit period All but $___ a day for 61st-90th days/benefit period All but $___ a day for 91st day and after while using 60 lifetime reserve days $0 once lifetime reserve days are used: Additional 365 days $0 beyond additional 365 days.	All but $___ for the first 60 days/benefit period All but $___ a day for 61st-90th days/benefit period All but $ [current amount] per day $0 once lifetime reserve days are used: Additional 365 days $0 beyond the additional 365 days.		
SKILLED NURSING FACILITY CARE Skilled nursing care in a facility approved by Medicare. Confinement must meet Medicare	First 20 days 100% of costs	First 20 days 100% of costs		

SERVICES	MEDICARE BENEFITS		YOUR [MEDICARE SUPPLEMENT OR MEDICARE ~~REPLACEMENT~~ COST] COVERAGE	
	In 2____, Medicare Pays Per Benefit Period	**Effective January 1, 2____, Medicare will Pay**	**In 2____, Your Coverage Pays**	**Effective January 1, 2____, Your Coverage will Pay Per Calendar Year**
standards. You must have been in a hospital for at least 3 days and enter the facility within 30 days after discharge.	All but $___ (current amount per day) for the 21st - 100th day $[0] of the 101st day and thereafter.	All but $___ (current amount per day) for the 21st - 100th day $[0] of the 101st day and thereafter.		
BLOOD	Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B	$0 for first 3 pints. 100% of additional amounts		
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care $0 or [ ]% of coinsurance or copayments	All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care $0 or [ ]% of coinsurance or copayments		□
MEDICARE PART B SERVICES AND SUPPLIES				
MEDICAL EXPENSES Eligible expense for physician's services, medical services in and out patient, physical and speech therapy, diagnostic tests, and durable medical equipment.	After $[ ] deductible, generally 80% of remainder of Medicare approved amounts	After $[ ] deductible, generally 80% of remainder of Medicare approved amounts		
HOME HEALTH CARE	100% of charges for visits considered medically necessary by Medicare		40 visits	
PREVENTIVE MEDICAL CARE BENEFIT Some annual physical and preventive tests	$0	$0	$120	

SERVICES	MEDICARE BENEFITS		YOUR [MEDICARE SUPPLEMENT OR MEDICARE ~~REPLACEMENT~~ COST] COVERAGE	
	In 2____, Medicare Pays Per Benefit Period	**Effective January 1, 2____, Medicare will Pay**	**In 2____, Your Coverage Pays**	**Effective January 1, 2____, Your Coverage will Pay Per Calendar Year**
and services administered or ordered by your doctor when NOT covered by Medicare				

[Note: Describe any coverage provisions changing due to Medicare modifications. Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.]

THIS CHART SUMMARIZES THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT OR MEDICARE COST] COVERAGE PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE CENTERS FOR MEDICARE & MEDICAID SERVICES. FOR INFORMATION ON YOUR [MEDICARE SUPPLEMENT OR MEDICARE COST] POLICY CONTACT:

[COMPANY OR FOR AN INDIVIDUAL POLICY - NAME OF AGENT]
[ADDRESS/PHONE NUMBER]

SECTION 94. INS 3.39 Appendices 6m and 6t are created to read:

INS 3.39 APPENDIX 6m

[NOTICE OF CHANGE FOR OUTLINE OF COVERAGE] [FOR APPLICANTS FIRST ELIGIBLE FOR MEDICARE AFTER JUNE 1, 2010 AND PRIOR TO JANUARY 1, 2020.]

(COMPANY NAME)
NOTICE OF CHANGES IN MEDICARE AND YOUR [MEDICARE SUPPLEMENT OR MEDICARE COST] COVERAGE – 2_____

THE FOLLOWING CHART BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR [MEDICARE SUPPLEMENT OR MEDICARE COST] COVERAGE.

PLEASE READ THIS CAREFULLY!

[Note: A brief description of the revisions to Medicare Parts A and B with a parallel description of supplemental benefits with subsequent changes, including dollar amounts, provided by the Medicare supplement or Medicare cost coverage in substantially the following format.]

SERVICES	MEDICARE BENEFITS		YOUR [MEDICARE SUPPLEMENT OR MEDICARE COST] COVERAGE	
	In 2____, Medicare Pays Per Benefit Period	**Effective January 1, 2____, Medicare will Pay**	**In 2____, Your Coverage Pays**	**Effective January 1, 2____, Your Coverage will Pay Per Calendar Year**
MEDICARE PART A SERVICES AND SUPPLIES				
HOSPITALIZATION Inpatient Hospital Services, Semi-Private Room & Board, Misc. Hospital Services &	All but $___ for the first 60 days/benefit period All but $___ a day for 61st-90th days/benefit period	All but $___ for the first 60 days/benefit period All but $___ a day for 61st-90th days/benefit period		

SERVICES	MEDICARE BENEFITS		YOUR [MEDICARE SUPPLEMENT OR MEDICARE COST] COVERAGE	
	In 2____, Medicare Pays Per Benefit Period	**Effective January 1, 2____, Medicare will Pay**	**In 2____, Your Coverage Pays**	**Effective January 1, 2____, Your Coverage will Pay Per Calendar Year**
Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room	All but $___ a day for 91st day and after while using 60 lifetime reserve days $0 once lifetime reserve days are used: Additional 365 days $0 beyond additional 365 days.	All but $ [current amount] per day $0 once lifetime reserve days are used: Additional 365 days $0 beyond the additional 365 days.		
SKILLED NURSING FACILITY CARE Skilled nursing care in a facility approved by Medicare. Confinement must meet Medicare standards. You must have been in a hospital for at least 3 days and enter the facility within 30 days after discharge.	First 20 days 100% of costs All but $___ (current amount per day) for the 21st - 100th day $[0] of the 101st day and thereafter.	First 20 days 100% of costs All but $___ (current amount per day) for the 21st - 100th day $[0] of the 101st day and thereafter.		
BLOOD	Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B	$0 for first 3 pints. 100% of additional amounts		
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care $0 or [ ]% of coinsurance or copayments	All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care $0 or [ ]% of coinsurance or copayments		☐
MEDICARE PART B SERVICES AND SUPPLIES				

SERVICES	MEDICARE BENEFITS		YOUR [MEDICARE SUPPLEMENT OR MEDICARE COST] COVERAGE	
	In 2____, Medicare Pays Per Benefit Period	**Effective January 1, 2____, Medicare will Pay**	**In 2____, Your Coverage Pays**	**Effective January 1, 2____, Your Coverage will Pay Per Calendar Year**
MEDICAL EXPENSES Eligible expense for physician's services, medical services in and out patient, physical and speech therapy, diagnostic tests, and durable medical equipment.	Generally 80% of remainder of Medicare approved amounts	Generally 80% of remainder of Medicare approved amounts		
HOME HEALTH CARE	100% of charges for visits considered medically necessary by Medicare		40 visits	
PREVENTIVE MEDICAL CARE BENEFIT Some annual physical and preventive tests and services administered or ordered by your doctor when NOT covered by Medicare	$0	$0	$120	

[Note: Describe any coverage provisions changing due to Medicare modifications. Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.]

THIS CHART SUMMARIZES THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT OR MEDICARE COST] COVERAGE PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE CENTERS FOR MEDICARE & MEDICAID SERVICES. FOR INFORMATION ON YOUR [MEDICARE SUPPLEMENT OR MEDICARE COST] POLICY CONTACT:

[COMPANY OR FOR AN INDIVIDUAL POLICY - NAME OF AGENT]
[ADDRESS/PHONE NUMBER]

INS 3.39 APPENDIX 6t

[NOTICE OF CHANGE FOR OUTLINE OF COVERAGE]
[FOR APPLICANTS NEWLY ELIGIBLE FOR MEDICARE ON OR AFTER JANUARY 1, 2020.]

(COMPANY NAME)
NOTICE OF CHANGES IN MEDICARE AND YOUR [MEDICARE SUPPLEMENT OR MEDICARE COST] COVERAGE – 2_____

THE FOLLOWING CHART BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR [MEDICARE SUPPLEMENT OR MEDICARE COST] COVERAGE.

PLEASE READ THIS CAREFULLY!

[Note: A brief description of the revisions to Medicare Parts A and B with a parallel description of supplemental benefits with subsequent changes, including dollar amounts, provided by the Medicare supplement or Medicare cost coverage in substantially the following format.]

SERVICES	**MEDICARE BENEFITS**		**YOUR [MEDICARE SUPPLEMENT OR MEDICARE COST] COVERAGE**	
	In 2____, Medicare Pays Per Benefit Period	**Effective January 1, 2____, Medicare will Pay**	**In 2____, Your Coverage Pays**	**Effective January 1, 2____, Your Coverage will Pay Per Calendar Year**
MEDICARE PART A SERVICES AND SUPPLIES				
HOSPITALIZATION Inpatient Hospital Services, Semi-Private Room & Board, Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room	All but $___ for the first 60 days/benefit period All but $___ a day for 61st-90th days/benefit period All but $___ a day for 91st day and after while using 60 lifetime reserve days $0 once lifetime reserve days are used: Additional 365 days $0 beyond additional 365 days.	All but $___ for the first 60 days/benefit period All but $___ a day for 61st-90th days/benefit period All but $ [current amount] per day $0 once lifetime reserve days are used: Additional 365 days $0 beyond the additional 365 days.		
SKILLED NURSING FACILITY CARE Skilled nursing care in a facility approved by Medicare. Confinement must meet Medicare standards. You must have been in a hospital for at least 3 days and enter the facility within 30 days after discharge.	First 20 days 100% of costs All but $___ (current amount per day) for the 21st - 100th day $[0] of the 101st day and thereafter.	First 20 days 100% of costs All but $___ (current amount per day) for the 21st - 100th day $[0] of the 101st day and thereafter.		
BLOOD	Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar	$0 for first 3 pints.		

SERVICES	MEDICARE BENEFITS		YOUR [MEDICARE SUPPLEMENT OR MEDICARE COST] COVERAGE	
	In 2____, Medicare Pays Per Benefit Period	**Effective January 1, 2____, Medicare will Pay**	**In 2____, Your Coverage Pays**	**Effective January 1, 2____, Your Coverage will Pay Per Calendar Year**
	year. Part A blood deductible reduced to the extent paid under Part B	100% of additional amounts		
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care $0 or [ ]% of coinsurance or copayments	All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care $0 or [ ]% of coinsurance or copayments		☐
MEDICARE PART B SERVICES AND SUPPLIES				
MEDICAL EXPENSES Eligible expense for physician's services, medical services in and out patient, physical and speech therapy, diagnostic tests, and durable medical equipment.	Generally 80% of remainder of Medicare approved amounts	Generally 80% of remainder of Medicare approved amounts		
HOME HEALTH CARE	100% of charges for visits considered medically necessary by Medicare		40 visits	
PREVENTIVE MEDICAL CARE BENEFIT Some annual physical and preventive tests and services administered or ordered by your doctor when NOT covered by Medicare	$0	$0	$120	

[Note: Describe any coverage provisions changing due to Medicare modifications. Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.]

THIS CHART SUMMARIZES THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT OR MEDICARE COST] COVERAGE PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS

CONTACT YOUR SOCIAL SECURITY OFFICE OR THE CENTERS FOR MEDICARE & MEDICAID SERVICES. FOR INFORMATION ON YOUR [MEDICARE SUPPLEMENT OR MEDICARE COST] POLICY CONTACT:

[COMPANY OR FOR AN INDIVIDUAL POLICY - NAME OF AGENT]
[ADDRESS/PHONE NUMBER]

SECTION 95. INS 3.39 Appendix 7 is amended to read:

INS 3.39 APPENDIX 7

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT, MEDICARE COST, MEDICARE SELECT, MEDICARE ADVANTAGE OR EXISTING ACCIDENT AND SICKNESS INSURANCE

(Insurance company'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, Medicare cost, Medicare select or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare supplement, Medicare cost, Medicare select or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement, Medicare cost, Medicare select, or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

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

_____Additional benefits.
_____No change in benefits, but lower premiums.
_____Fewer benefits and lower premiums.
_____My plan has prescription drug coverage and I am enrolling in Medicare Part D.
_____Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]

_____
_____

Other. (please specify)

_____
_____
_____
_____

1. Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing ~~pre-existing~~ preexisting condition limitations, please skip to statement 2 below. Health conditions that you may presently have (~~pre-existing~~ 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 ~~condition~~ conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary

periods in the new policy (or coverage) for similar benefits to the extent such time was satisfied under the Medicare supplement 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 requested material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all requested information has been properly reported. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

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

_____

(Signature of Agent, Broker or Other Representative)*
[Typed Name and Address of Issuer, Agent or Broker]

_____

(Applicant's Signature)

_____

(Date)

* Signature not required for direct response sales.

SECTION 96. INS 3.39 Appendices 8 and 9 are repealed.

SECTION 97. INS 3.55 (title), (1) and (2) are amended to read:

INS 3.55 (title) Benefit appeals under long-term care policies, life insurance-long-term care coverage ~~and Medicare replacement and supplement policies~~.

(1) PURPOSE. This section implements and interprets s. 632.84, Stats., for the purpose of establishing minimum requirements for the internal procedure for benefit appeals that insurers shall provide in long-term care policies, life insurance-long-term care coverage ~~and Medicare replacement or supplement policies~~. This section also facilitates the review by the commissioner of these policy forms.

(2) SCOPE. This section applies to individual and group nursing home insurance policies ~~and Medicare replacement or supplement policies~~ issued or renewed on or after August 1, 1988, and to long-term care policies and life insurance-long-term care coverage issued or renewed on and after June 1, 1991, except for polices or coverage exempt under s. Ins 3.455 (2) (b). This section does not apply to health maintenance organizations, limited service health organization or preferred provider plan, as those are defined in s. 609.01, Stats.

SECTION 98. INS 3.55 (3) (d) and (e) are repealed.

SECTION 99. INS 3.55 (4) (a) and (5) (intro.) are amended to read:

INS 3.55 (4) (a) Pursuant to s. 632.84 (2), Stats., an insurer shall include an internal procedure for benefit appeals in any long-term care policy~~,~~ or life insurance-long-term care coverage ~~any Medicare replacement cost or supplement policy an internal procedure for benefit appeals~~.

(5) REPORTS TO THE COMMISSIONER. An insurer offering a long-term care insurance policy or rider shall report to the commissioner by March 31 of each year a summary of all benefit appeals filed during the previous calendar year and the disposition of these appeals, including:

SECTION 100. INS 9.01 (3m) is amended to read:

INS 9.01 (3m) "Defined network plan" has the meaning provided under s. 609.01 (1b), Stats., and includes Medicare select policies~~, Medicare Select policy~~ and certificates as defined in s. Ins 3.39 ~~(30) (b) 4.~~ (3) (vm) and (ve), respectively, and health benefit plans that contract for use of participating providers.

SECTION 101. EFFECTIVE DATE. This rule is effective on the first day of the month commencing after the date of publication in the Wisconsin Administrative Register in accordance with s. 227.22 (2) (intro.), Stats.

Dated at Madison, Wisconsin, this 12th day of August, 2019.

Nathan D. Houdek
Deputy Commissioner

STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
DOA-2050 (C04/2012)

DIVISION OF EXECUTIVE BUDGET AND FINANCE
101 EAST WILSON STREET, 10TH FLOOR
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EXISTING ADMINISTRATIVE RULES
Fiscal Estimate & Economic Impact Analysis

1. Type of Estimate and Analysis
☐ Repeal ☒ Modification

2. Administrative Rule Chapter, Title and Number
Ch Ins 3 Casualty Insurance s. Ins 3.39 and 3.55

3. Date Rule promulgated and/or revised; Date of most recent Evaluation
Ins 3.39 - May 2010 Ins 3.55 November 2008

4. Plain Language Analysis of the Rule, its Impact on the Policy Problem that Justified its Creation and Changes in Technology, Economic Conditions or Other Factors Since Promulgation that alter the need for or effectiveness of the Rule.

Wisconsin is a waived state regarding the regulation of Medicare supplemental products meaning that the state is waived from implementing the standardized Medicare supplement Plans A to N, and instead uses standardized supplemental benefits with seven benefit riders. This is advantageous to both the insurer and the consumers as this system permits consumers to compare products on an equal basis to determine the best product to meet their insurance needs. Insurers are able to rely upon a consistent regulatory scheme that is stable with few changes since 1990. The federal government incorporated the National Association of Insurance Commissioners Medicare supplement model act within the federal regulations following passage of the Medicare Access and CHIP Reauthorization Act of 2015 that requires Medicare supplemental policies issued to individuals that are first eligible for Medicare benefits on or after January 1, 2020, not contain the option to purchase a Part B deductible rider. This change does not affect those who already have the Part B deductible rider as those plans are guaranteed renewable for life.

The remainder of the proposed rule; updates terminology, creates consistency in numbering and references, and updates and simplifies the appendices to the rule. However, as noted previously, since Medicare supplement and Medicare select plans are guaranteed renewable for life, the OCI cannot repeal original or previous federal law changes as individuals may still have existing policies regulated under this section. Instead the OCI in this draft adopts a parallel citation approach for ease of navigation. By promulgating this rule the state will be able to retain regulatory jurisdiction over these products.

5. Describe the Rule's Enforcement Provisions and Mechanisms

The rule interprets ss. 185.983 (1m), 600.03, 601.01 (2), 609.01 (1g) (b), 625.16, 628.34 (12), 628.38, 631.20 (2), 632.73 (2m), 632.76 (2) (b) and 632.81, 632.84, 632.895 (2), (3), (4), and (6), Wis. Stats., that are enforced under s. 601.41 (4) and 601.64, Wis. Stats.

6. Repealing or Modifying the Rule Will Impact the Following (Check All That Apply)
☐ State's Economy
☐ Local Government Units
☐ Specific Businesses/Sectors
☐ Public Utility Rate Payers
☐ Small Businesses

7. Summary of the Impacts, including Compliance Costs, identifying any Unnecessary Burdens the Rule places on the ability of Small Business to conduct their Affairs.

Insurers offering Medicare supplemental products will need to file new policy forms, advertising and rates with the OCI, and consumers will pay the Part B medical deductible directly rather than pay premium for use of the deductible rider. The difference in cost to the consumer will be negligible as the premium for the rider closely parallels the amount of the Part B medical deductible. The advantage of the Part B deductible rider was the ability to distribute the deductible evenly over 12-months rather than pay the deductible as incurred.

8. List of Small Businesses, Organizations and Members of the Public that commented on the Rule and its Enforcement and a Summary of their Comments.

The request for comment on the proposed rule was sent to 50 organizations and individuals. Additionally the OCI posted the Request for Comment on its public website. The OCI received four comments on the rule from the following organizations and an individual: America's Health Insurance Plans Association, Attorney William Schiffbauer, Wisconsin Association of Health Plans, and UnitedHealth Group. All comments were similar and identified that the rule

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EXISTING ADMINISTRATIVE RULES
Fiscal Estimate & Economic Impact Analysis

draft was more restrictive than the federal requirement regarding the ability of persons eligible for Medicare prior to 2020 to obtain the Part B medical deductible rider after January 1, 2020, as the benefits consumers may elect are tied to the date of their initial eligibility not the date they seek coverage through a supplemental product. The OCI has revised the rule to fully address this concern.

9. Did the Agency consider any of the following Rule Modifications to reduce the Impact of the Rule on Small Businesses in lieu of repeal?

☐ Less Stringent Compliance or Reporting Requirements
☐ Less Stringent Schedules or Deadlines for Compliance or Reporting
☐ Consolidation or Simplification of Reporting Requirements
☐ Establishment of performance standards in lieu of Design or Operational Standards
☐ Exemption of Small Businesses from some or all requirements
☒ Other, describe: The rules change minimum necessary to retain regulatory jurisdiction over Medicare supplement products.

10. Fund Sources Affected	11. Chapter 20, Stats. Appropriations Affected
☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S	None

12. Fiscal Effect of Repealing or Modifying the Rule

☒ No Fiscal Effect	☐ Increase Existing Revenues	☐ Increase Costs
☐ Indeterminate	☐ Decrease Existing Revenues	☐ Could Absorb Within Agency's Budget
		☐ Decrease Cost

13. Summary of Costs and Benefits of Repealing or Modifying the Rule

The proposed rule will not significantly impact the private sector. Insurers offering Medicare supplement policies (Medicare supplement, Medicare cost, and Medicare select policies) may incur costs associated with developing new Medicare supplement policies and marketing materials, mailing riders and explanatory materials to existing policyholders. However, these costs are offset by the insurers' ability to continue offering Medicare supplement policies to Wisconsin consumers. Further, removing the Part B medical deductible rider as an optional purchase will not adversely impact consumers, agents or insurers since the typical premium for Part B medical deductible rider closely approximates the actual deductible amount that for 2019 will be $185.00.

14. Did the Agency prepare a Cost Benefit Analysis (if Yes, attach to form)

☐ Yes ☒ No

15. Long Range Implications of Repealing or Modifying the Rule

Wisconsin will retain the ability to regulate the Medicare supplement market and provide consumer protection.

16. Compare With Approaches Being Used by Federal Government

Wisconsin is a waived state regarding the regulation of Medicare supplemental products. This rule will bring Wisconsin into compliance with federal requirements that will be implemented beginning Jnauary 1, 2020, for Medicare supplemental products. Wisconsin's Medicare supplement product structure is comprised of a base insurance product with seven riders. This is advantagous to both the insurer and the consumers as this system permits consumers to compare products on an equal basis to determine the best product to meet their insurance needs. Insurers are able to rely upon a consistent regulatory scheme that is stable with few changes since 1990.

17. Compare With Approaches Being Used by Neighboring States (Illinois, Iowa, Michigan and Minnesota)

All states are required to comply with the federal changes to Medicare supplement. The main difference for Wisconsin as compared to neighboring states is how Wisconsin has historically structured the supplemental products sold to Wisconsin consumers using a base product with riders.

18. Contact Name	19. Contact Phone Number
Julie E. Walsh	608-264-8101

Tony Evers
Office of the Governor | State of Wisconsin

August 9, 2019

By Electronic Mail Only

Dear Secretaries and Agency Heads:

On this day, I approved the following statements of scope pursuant to Wis. Stat. § 227.135(2):

- A statement of scope by the Chiropractic Examining Board, dated June 27, 2019, relating to courses of study for and delegation to chiropractic technicians and chiropractic radiological technicians (Wis. Admin. Code ch. Chir 10); and
- A statement of scope by the Optometry Examining Board, dated May 30, 2019, relating to unprofessional conduct (Wis. Admin. Code ch. Opt 5); and
- A statement of scope by the Department of Safety and Professional Services, dated May 9, 2019, relating to tattooing and body piercing (Wis. Admin. Code ch. SPS 221); and
- A statement of scope by the Department of Administration, dated April 22, 2019, relating to updating standards to implement the Uniform Real Property Electronic Recording Act (Wis. Admin. Code ch. Adm 70); and
- A statement of scope by the Examining Board of Architects, Landscape Architects, Professional Engineers, Designers, and Professional Land Surveyors, dated April 23, 2019, relating to general procedures (Wis. Admin. Code ch. A-E 2); and
- A statement of scope by the Examining Board of Architects, Landscape Architects, Professional Engineers, Designers, and Professional Land Surveyors, dated April 23, 2019, relating to professional conduct (Wis. Admin. Code ch. A-E 8); and
- A statement of scope by the Examining Board of Architects, Landscape Architects, Professional Engineers, Designers, and Professional Land Surveyors, dated April 23, 2019, relating to architect registration examinations (Wis. Admin. Code ch. A-E 3); and
- A statement of scope by the Department of Public Instruction, dated July 16, 2019, for an emergency and permanent rule relating to clarifying high cost special education aid (Wis. Admin. Code ch. PI 30); and
- A statement of scope by the Department of Natural Resources dated July 15, 2019, relating to targeted performance standards and prohibitions to abate pollution of groundwater by nitrate sensitive areas (Wis. Admin. Code chs. NR 151 and 243).

On this day, I approved the following proposed administrative rules pursuant to Wis. Stat. § 227.185:

- A proposed rule by the Optometry Examining Board, submitted on June 12, 2019, relating to licensure by endorsement (Wis. Admin. Code ch. Opt 4); and
- A proposed rule by the Optometry Examining Board, submitted on July 18, 2019, relating to diagnostic and therapeutic pharmaceutical agents (Wis. Admin. Code ch. Opt 6); and
- A proposed rule by the Chiropractic Examining Board, submitted on July 3, 2019, relating to delegation of services to health care professionals (Wis. Admin. Code chs. Chir 1, 4, 10 and 11); and
- A proposed rule by the Accounting Board, submitted on June 11, 2019, relating to continuing professional education (Wis. Admin. Code chs. Accy 2 and 7); and
- A proposed rule by the Department of Health Services, submitted on July 8, 2019, relating to a uniform fee system (Wis. Admin. Code ch. DHS 1); and
- A proposed rule by the Office of the Commissioner of Insurance dated July 3, 2019, relating to Medicare supplement insurance (Wis. Admin. Code ch. INS 3).

Please direct any questions about this letter to my policy director, Jenni Dye.

Sincerely,

Tony Evers
Governor

Cc: Ryan Nilsestuen, chief legal counsel (ryan.nilsestuen1@wisconsin.gov)
Jenni Dye, policy director (jenni.dye@wisconsin.gov)
DOA State Budget Office (SBOAdminRules@spmail.enterprise.wistate.us).
DSPS (DSPSAdminRules@wisconsin.gov)
Davis Ciotola, DHS (Davis.Ciotola@dhs.wisconsin.gov).
Daniela Branco, DNR (DanielaH.Branco@wisconsin.gov)
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Carl Bryan, DPI (carl.bryan@dpi.wi.gov)
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Nathan Houdek, OCI (nathan.houdek@wisconsin.gov)

WISCONSIN LEGISLATIVE COUNCIL
RULES CLEARINGHOUSE

Scott Grosz
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Margit Kelley
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Jessica Karls-Ruplinger
Legislative Council Deputy Director

CLEARINGHOUSE RULE 19-036

Comments

[NOTE: All citations to "Manual" in the comments below are to the Administrative Rules Procedures Manual, prepared by the Legislative Reference Bureau and the Legislative Council Staff, dated December 2014.]

2. Form, Style and Placement in Administrative Code

a. In the rule summary's listing of statutory authority, consider revising the citations to be more precise. For example:

(1) The citation to s. 601.41, Stats., could more precisely cite to sub. (3) of that section.

(2) The citation to s. 628.34, Stats., could more precisely cite to sub. (12) of that section.

(3) The citation to s. 632.73, Stats., could more precisely cite to subs. (2m) and (3) (b) of that section.

(4) The citation to s. 632.76, Stats., could more precisely cite to sub. (2) (b) of that section.

b. In the rule summary, if a preliminary hearing and comment period was held on the scope statement for the proposed rule, a heading and entry should be inserted to provide a summary of the public comments received and a description of how the feedback was taken into account in drafting the proposed rule. [s. 227.14 (2) (a) 3m., Stats.]

c. In SECTION 9 of the proposed rule, the text of s. Ins 3.39 (2) (c) 1. should not be shown. It is properly repealed in its entirety in SECTION 10 of the proposed rule. [ss. 1.057 and 1.06 (1) (b), Manual.]

d. In SECTION 19 of the proposed rule, the definition for the term "Medicare cost policy" should be renumbered to appear in alphabetical order.

e. In SECTION 21 and in other instances in the proposed rule, the reference to the Social Security Act should not be capitalized. [s. 1.01 (4), Manual.]

f. In SECTION 30 of the proposed rule, consider revising the renumbering to s. Ins 3.39 (4d), rather than reusing the current s. Ins 3.39 (4m) for the renumbering from s. Ins 3.39 (4s). Reusing a previously existing number can cause confusion. [s. 1.03 (5), Manual.]

g. In SECTIONS 31 to 33 of the proposed rule, it appears that the affected provisions should be identified as originating in s. Ins 3.39 (4s), rather than s. Ins 3.39 (4m), and should be grouped with the provisions from sub. (4s) that are renumbered and amended in SECTION 30 of the proposed rule.

h. In SECTION 37 of the proposed rule, the treatment clause should be revised to state that s. Ins 3.39 (5m) (a) 1. is renumbered to s. Ins 3.39 (5m) (a) 1. (intro.), in order to identify both "3.39" and the new introductory material. The rule caption's listing of provisions treated in the proposed rule should also be revised to include this provision among the provisions that are renumbered and amended, rather than among the provisions amended.

i. In the treatment clause for SECTION 38 of the proposed rule, the designation "3.39" should be inserted. Also, this SECTION creates a new subpar. a., but there do not appear to be any other subdivision paragraph units to accompany subpar. a. When a unit is divided into smaller units, at least two subunits must be created. Were additional subunits intended to be created? If so, those should be inserted. Otherwise, the subdivision paragraph should be incorporated into its parent subdivision and the renumbering to "(intro.)" in SECTION 37 as noted in the previous comment would not be needed.

j. In the treatment clause for SECTION 39 of the proposed rule, the designation "(intro.)" should be inserted. The rule caption's listing of provisions treated in the proposed rule should also be updated accordingly.

k. In SECTION 49 of the proposed rule, in the title for s. Ins 3.39 (8), the period at the end of the title should be shown as it is in current rule.

l. In SECTION 53 of the proposed rule, the citation to 42 U.S.C. s. 1395 should not be enclosed in parentheses. Rather, the citation should be set apart with commas or described in a note. [s. 1.01 (6), Manual.] Also, if the abbreviation "ss" after the citation is intended to mean that it includes the following sections, the abbreviation "et seq." is more commonly used.

m. In SECTION 54 of the proposed rule, the final period should not be underscored.

n. In the treatment clause for SECTION 39 of the proposed rule, the designation "(intro.)" should be inserted after "(f)". The rule caption's listing of provisions treated in the proposed rule should also be updated accordingly.

o. In SECTION 64 of the proposed rule, are any amendments intended for s. Ins 3.39 (26) (a) (intro.)? Any intended amended material should be shown with strike-throughs and underscoring. Otherwise, if no amendments are intended, the text of that provision should be removed.

p. In SECTION 72 of the proposed rule, s. Ins. 3.39 (31) (a) (intro.), the word "following" should be inserted before the word "information", and the provision should end in a colon rather than a period.

q. In SECTION 90 of the proposed rule, the title for s. Ins 3.55 (5) should be shown even though it is not amended. [s. 1.05 (3) (c), Manual.]

r. In SECTION 93 of the proposed rule, the phrase "in the Wisconsin Administrative Register" should be inserted after the word "publication". Also, the citation to s. 227.22, Stats., should more precisely cite to sub. (2) (intro.) of that section.

4. Adequacy of References to Related Statutes, Rules and Forms

Cross-references to provisions for which the numbering is revised in response to these comments should be reviewed and updated as necessary.

5. Clarity, Grammar, Punctuation and Use of Plain Language

a. In SECTION 3 and in other instances of the proposed rule, the terms "Medicare supplement" and "Medicare cost" should not be used as stand-alone terms. This creates ambiguity because these are undefined terms that may be confused with "Medicare supplement policy" (defined in statute), "Medicare supplement coverage" (defined in the administrative code), or "Medicare cost policy" (defined in the proposed rule).

b. References in the proposed rule to "Medicare supplement or Medicare cost insurance" should also be revised to avoid creating ambiguity. For example, if this is intended as a reference to two defined terms, it could be revised to refer to a "Medicare supplement policy or Medicare cost policy", or to "Medicare supplement coverage or Medicare replacement coverage".

c. SECTIONS 6 and 8 of the proposed rule refer to a "Medicare cost policy" as defined in s. 600.03 (28p) (a) and (c), Stats. However, that provision defines a "Medicare replacement policy", and not a "Medicare cost policy". Consider revising the phrase "as defined in" to the phrase "as described in", or making any other appropriate revision to align the terminology. Also, the reference to pars. (a) and (c) is confusing because it leaves out par. (b), which is a part of the statutory definition. Paragraph (b) refers to Medicare+choice plans which are now known as Medicare Advantage plans (defined in the administrative code). Are Medicare Advantage plans intended to be excluded? Lastly, these references are in conflict with SECTION 19 of the proposed rule, which defines the term "Medicare cost policy" in a different way. Consider revising the terms for consistency.

d. In SECTION 23 of the proposed rule, references to a "Medicare supplement individual policy" and "Medicare cost individual policy" should be revised to avoid creating ambiguity, as these are not defined terms. The provision could be revised to refer to an "individual Medicare supplement policy" or an "individual Medicare cost policy".

e. In SECTION 24 of the proposed rule, the reference to a Medicare select policy is potentially ambiguous because it is redundant. Under the rule, any Medicare select policy is by definition a Medicare supplement policy.

f. In SECTION 24 and in other instances throughout the proposed rule, the reference to a "Medicare supplement policy or certificate" is redundant. Under the statutory definition of a "Medicare supplement policy", the term already includes certificates. Is this intended to refer just to a Medicare supplement policy (which includes certificates)? Or is it supposed to refer to "Medicare select policy or Medicare select certificate"? Also, if the references to "policy or certificate" are retained in the rule, they should be used consistently throughout the text. Various provisions in the text refer to "policy or certificate" in one instance and then later refer only to "the policy", which creates additional ambiguity.

g. In SECTION 26 of the proposed rule, each reference to a "Medicare supplement or certificate" is confusing. This is not a defined term and each instance should be revised to adequately identify to what the provisions apply.

h. In SECTION 29 and in other instances throughout the proposed rule, the reference to Medicare select policies, following a reference to Medicare supplement coverage, is potentially ambiguous because it is redundant. Under the rule, any Medicare select policy is by definition a Medicare supplement policy.

i. SECTION 45 of the proposed rule refers to a "Medicare cost issuer" as defined in s. 600.03 (28p) (a) and (c), Stats. However, that provision defines a "Medicare replacement policy", and not a "Medicare cost issuer". Consider revising the provision to refer to "an issuer of a Medicare replacement policy as defined in", or making any other appropriate revision to align the terminology. Also, the reference to pars. (a) and (c) is confusing because it leaves out par. (b), which is a part of the statutory definition. Paragraph (b) refers to Medicare+choice plans which are now known as Medicare Advantage plans (defined in the administrative code). Are Medicare Advantage plans intended to be excluded?

j. In SECTION 71 of the proposed rule, in s. Ins 3.39 (30t) (k) (intro.), the final sentence should be revised for a better grammatical insertion of the phrase "include all of the following". For example, the "and" after "settlement" could be revised to a comma, a comma could be inserted after "arbitration procedures", and the word "shall" or "may" could be inserted before "include all of the following". Additionally, the final sentence should end in a colon rather than a period. These comments also apply to the corollary provision in s. Ins 3.39 (30) (k) (intro.), which could be amended in the proposed rule.

k. In SECTION 71 of the proposed rule, s. Ins 3.39 (30t) (s) (intro.), consider revising the introductory language. In particular, the "designation" in subd. 1. is not a type of "coverage" as indicated in the introduction.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tony Evers, *Governor*
Mark V. Afable*, Commissioner*

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July 2, 2019

Report on Section Ins 3.39 and 3.55, Wis. Adm. Code, relating to Medicare supplement insurance and affecting small business

Clearinghouse Rule No. 19-036
Submitted Under s. 227.19 (3), Stats.

(The proposed rule-making order is attached.)

(a) A detailed statement of basis for the proposed rule and how the rule advances relevant statutory goals or purposes:

The proposed rule amends the current rules to incorporate the National Association of Insurance Commissioners (NAIC) model regulation that implements the Medicare Supplement Insurance Minimum Standards Model Act to comply with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Medicare supplement policies are policies purchased by Medicare beneficiaries to cover Medicare deductibles, co-insurance and selected services that Medicare does not cover. Medicare establishes eligibility rules, benefits and coverage limits through standardized Medicare supplement Plans A to N. However, Wisconsin is a waived state, meaning Wisconsin is waived from implementing the federal lettered plans, and instead Wisconsin requires minimum standardized supplemental benefits with seven standardized benefit riders. This is advantageous to both the insurer and the consumers as this system permits consumers to compare products on an equal basis to determine the best product to meet their insurance needs.

However, beginning with January 1, 2020, Wisconsin must redefine the eligibility of individual who may purchase, and insurers who may advertise and sell, one of the seven riders. Specifically, MACRA requires that policies issued to individuals who are first eligible for Medicare benefits on or after January 1, 2020, not have the option to purchase coverage for the Medicare Part B medical deductible rider. This change does not affect those who became eligible for Medicare prior to January 1, 2020, through age or disability, including end-stage renal disease.

The remainder of the proposed rule; updates terminology, creates consistency in numbering and references, and updates and simplifies the appendices to the rule. However, as noted previously, since Medicare supplement and Medicare select plans are guaranteed renewable for life, the Office of the Commissioner of Insurance (OCI) cannot repeal original rule text that was based upon previous federal law changes since individuals may still have existing policies regulated under prior sections. Instead the OCI, in this draft, adopts a parallel citation approach for ease of navigation. Subsections that apply to all plans or a plan issued to groups or individuals who were first eligible for Medicare prior to June 1, 2010, appear with just a number, i.e. s. Ins 3.39 (4), Wis. Adm. Code. All appendices and subsections that apply to policies issued to groups or individuals who were first eligible for Medicare on or after June 1, 2010, and prior to January 1, 2020, appear as a number with the letter “m” following the number, i.e. s. Ins 3.39 (4m), Wis. Adm. Code. For the new plans that will be issued to groups or individuals who are newly eligible for Medicare on or after January 1, 2020, all appendices and subsections appear as a number with the letter “t” following the number, i.e. s. Ins 3.39 (4t), Wis. Adm. Code. Finally, there are citation

corrections within cross references to existing or newly created s. Ins 3.39, Wis. Adm. Code, provisions within the insurance administrative code.

(b) Summary of the public comments and the agency's responses to those comments:

Comment: Rule draft was ambiguous whether Medicare Part B deductible rider could be sold after January 1, 2020 to persons eligible prior to January 1, 2020 when the Medicare changes under MACRA take effect.

Response: Changed language to clarify that the rider can be sold to persons eligible prior to January 1, 2020.

Comment: Definition of newly eligible was not the same as the NAIC model regulation draft.

Response: Modified the definition to more closely mirror the NAIC model regulation.

Comment: Rule draft appeared to prohibit marketing of the Medicare Part B deductible rider after January 1, 2020.

Response: Clarified that marketing is permitted to persons eligible for Medicare prior to January 1, 2020.

Comment: Subsection titles appeared inconsistent with the content of the subsection regarding effective dates.

Response: Amended all titles for consistency and accuracy.

Comment: Appendices missing column headers for insured payment responsibility.

Response: Amended Appendices for consistency, and that benefits are tied to when the person was first eligible for Medicare.

Comment: Suggestion that a phrase within the Medicare Part B copayment and coinsurance rider referencing Part B deductible be removed.

Response: The wording of the rule is accurate; no changes are needed.

(c) An explanation of any modifications made in proposed rule as a result of public comments or testimony received at a public hearing:

The office revised the proposed rule to incorporate the suggestions contained in the comments received. The primary concern raised was to ensure that consumers could maintain and obtain the Medicare Part B deductible rider after January 1, 2020 provided the consumer was eligible for Medicare prior to January 1, 2020. Modification included amending the title naming convention from effective date of policies to eligibility date of the consumer. The revisions made throughout the proposed rule were made to ensure language is clear and unambiguous regarding the federal change to Medicare supplemental coverage under MACRA.

(d) Persons who appeared or registered regarding the proposed rule:

Appearances for:
None

Appearances against:
None

Appearances for information:
Guenther Ruch
Jill Helgeson, BOALTC
Rick Erickson

Registrations for:
None

Registrations against:
None

Registrations neither for nor against:
Amy Sholis, NeuGen LLC
Will Kramer and Michelle Littel, WPS Health Ins.
John Trochell, MercyCare Health Ins.
Jonathon Moody and Elena Haffenbredl, Quartz Ins.
Mary Haffenbredl, America's Health Insurance Plans (AHIP)
Kelsey Avery, Wisconsin Association of Health Plans (WAHP)

Letters received:
Guenther Ruch
Heather Jerbi, AHIP
Michelle Littel, WPS Health Insurance
LisaAnne Keller, UnitedHealthcare Insurance Company
Kelsey Avery, WAHP
Rick Erickson

(e) An explanation of any changes made to the plain language analysis of the rule under s. 227.14 (2), Stats., or to any fiscal estimate prepared under s. 227.14 (4), Stats.

The plain language was reviewed to ensure consistency with the modification made to the rule in light of the Legislative Council recommendation and public comment received.

(f) The response to the Legislative Council staff recommendations indicating acceptance of the recommendations and a specific reason for rejecting any recommendation:

All comments were complied with and corrected with the exception of reusing a number currently in the regulation. In order to achieve the three silos for identifying the requirements and benefits based upon date a person is first eligible for Medicare. Specifically, OCI reused Ins 3.39 (4m) citation but followed all Legislative Council suggestions if OCI decided to continue reusing the subsection.

(g) The response to the report prepared by the small business regulatory review board:

The small business regulatory review board did not prepare a report.

(h) Final Regulatory Flexibility Analysis

A Final Regulatory Flexibility Analysis is Not Required because the rule will not have a significant economic impact on a substantial number of small businesses.

(i) Fiscal Effect

See fiscal estimate attached to proposed rule.

Attachment: Legislative Council Staff Recommendations