State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, *Governor*
Theodore K. Nickel*, Commissioner*

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December 13, 2018

Request for Comment

The Office of the Commissioner of Insurance (OCI) is considering promulgating a permanent rule regarding ss. Ins 3.39 and 3.55, Wis. Adm. Code, relating to Medicare supplement insurance and affecting small business. The OCI is accepting comments on the fiscal impact of the rule draft from businesses, governmental units, and individuals that may be affected by a permanent rule based upon the text of the permanent rule. Please send comments to Mr. Jeff Grothman at Jeff.Grothman@wisconsin.gov.

Comments must be received by 4:30 p.m. on December 28, 2018.

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 (30) (b) and (30m) (b); Appendices 8 and 9; to renumber Ins 3.39 (5m) (b) and (c); Appendix (2); to renumber and amend Ins 3.39 (4m); (4s); (34) (ez); Appendix 3; Appendix (4); Appendix 5; to amend Ins 3.39 (1); (2) (a), (b), (c), and (d) (intro.) and 4.; (3) (c) (intro.) 1., (r), (v), (w); (4) (title) and (intro.), (a) (intro.) 4., 5., 7., 9., 10., 11., 12., and 18r., (b) (intro.), 1., 3., 5., 7., (c) (intro.) and 1., (e) (intro.) and 1.; (5m) (a) 2., (e); (6) (intro.); (7) (title), (a) (intro.), (b), (c) and (dm); (8) (title), (a), (c), and (e); (13), (14) (a), (c) (intro.) 1. to 6., and (i), (14m) (a), (c) 1. to 6., and (i); (16) (c), (d) (intro.) and 3., and (e), (17); (21) (a); (22) (d), and (f) and 1.; (23) (c) and (e); (24) (a); (25) (a), (b), and (c); (26) (b); (27); (28) (c); (29) (a); (30) (o), and (30m) (i) 1. and 8., (o), and (q); (34) (title), (a) 1., 2., (b) (title) and (intro.), (e) 4. and 5.; (35) (a); Appendix 6; Appendix 7; Ins 3.55 (4) (a) and (5) (intro.); to repeal and recreate Ins 3.39 (31) (a), (b) and (bm); to create Ins 3.39 (3) (ce), (gm), (jm), (qm), (vg), (vr), (wg), (wr), (zbm), (zcm), (zf) and (3g), (4s); (5s); (7) (cs) and (ds); (14s); (21) (f); (30s); (34) (es); Appendices 2s, 3s, 4s, 5s, 6m and 6s; Ins 3.55 (5m), 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 approved by the Commissioner on August 28, 2018.

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, 625.16, 628.34, 628.38, 632.73, 632.76, 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, 625.16, 628.38, 632.73, 632.76, 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 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 offer after January 1, 2020. Specifically, although Wisconsin is a waived state, meaning Wisconsin is waived from implementing the standardized Medicare supplement plans as the state had standardized supplemental benefits prior to 1990, to retain regulatory oversight of the Medicare supplement marketplace, MACRA requires that 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 tool for ease of navigating the rule. Subsections that apply to all plans or plan issued prior to June 1, 2010 appear with just a number, i.e. Ins 3.39 (4). All appendices and subsections that apply to policies issued on or after June 1, 2010 and prior to January 1, 2020 appear as a number with the letter "m" following, i.e. Ins 3.39 (4m). For the new plans that will be issued on or after January 1, 2020, all appendices and subsections appear as a number with the letter "s" following, i.e. Ins 3.39 (4s).

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 with 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 thereby not subjecting Wisconsin consumers to the federal alphabet soup associated with Medicare supplemental plans 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. This approach allows consumers easy "apple to apple" comparison of products and options available for the supplemental needs.

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

Illinois: 50 Ill. Adm. Code 2008, ss 2008.67(f)(7), 2008.APPENDIX W, 2008.APPENDIX EE, and 2008.APPENDIX FF, and 2008.63, 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: The Iowa Department of Insurance gave notice of intent to rule-making dated Sept. 24, 2018.Please note that as Wisconsin is a waived state for Medicare supplemental insurance there are no similar rules in adjacent states.

Michigan: Mich. Comp. Laws ch. 38, ss. 500.3801 to 500.3861, however, there are no similar modifications for the MACRA changes. 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, however, there are no similar modifications for the MACRA changes. Please note that as Wisconsin is a waived state for Medicare supplemental insurance there are no similar rules in adjacent states.

8. 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 review of complaints, NAIC models, insurer's financial information 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.

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 market Medicare supplement coverage in Wisconsin. At year-end 2017, there were 289,662 Wisconsin Medicare beneficiaries with Medicare supplement policies.

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

9. 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.

10. 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 Part B deductible rider as an optional purchase will not adversely impact consumers, agents or insurers as the typical premium for Part B deductible riders closely approximated the actual deductible amount that for 2019 will be $185.00.

11. 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 Part B deductible rider as an optional purchase with not adversely impact consumers, agents or insurers as the typical premium for Part B riders closely approximated the actual deductible amount that for 2019 will be $185.00.

12. 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

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

The deadline for submitting comments is 4:00 p.m. on the 14th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

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Legal Unit - OCI Rule Comment for Rule Ins xxx
Office of the Commissioner of Insurance
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The proposed rule changes are:

SECTION 1. Ins 3.39 (1) is amended to read:

Ins 3.39 **(1)** PURPOSE. **(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.

~~(c) Further any disability insurance policy or certificate that is designed to reduce or eliminate “gaps” arising from the coverages in a Medicare Advantage or Medicare Part D Prescription Drug plan must be compliant with this section, and pursuant to s. 104 (c) of Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), policies that are advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare Advantage plans must comply with Medicare supplement requirements of s. 1882 (o) the federal Social Security Act (42 U.S.C. Section 1395 et. seq.).~~

(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 (6) and (9), Stats.

SECTION 2. Ins 3.39 (2) (a), (b), (c), and (d) (intro.) and 4., 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 as defined in s. 600.03 (28r), Stats., or any Medicare ~~replacement~~ cost policy as defined in s. 600.03 (28p) (a) and (c), Stats., including all of the following:

1. Any Medicare supplement 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~~ cost 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~~.

~~4. Any conversion contract offered to a Medicare eligible person, if the prior individual or group policy includes no provision inconsistent with the requirements of this section.~~

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 or a Medicare ~~replacement~~ cost policy as described in par. (a).

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

~~1. Any conversion policy which is offered to a person eligible for Medicare as a replacement for prior individual or group hospital or medical coverage, other than a Medicare supplement or a Medicare cost policy described in par. (a); and~~

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

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

~~4. A conversion contract offered to a Medicare eligible person as a replacement for prior individual or group hospital, surgical, medical, major medical, or comprehensive medical expense coverage, if the prior policy includes provisions which are inconsistent with the requirements of this section.~~

SECTION 3. Ins 3.39 (3) (c) (intro.) 1., is amended to read:

Ins 3.39 (3) (c) "Applicant" means either of the following: 1. In the case of an individual Medicare supplement or Medicare ~~replacement~~ cost policy, the person who seeks to contract for insurance benefits.

SECTION 4. Ins 3.39 (3) (ce), (gm), (jm) and (qm), are created to read:

Ins 3.39 (3) (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.

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

(jm) “Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare select policy or certificate with the administration, claims practices or provision of services concerning a Medicare select issuer or its network providers.

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

SECTION 5. Ins 3.39 (3) (r), and (v), are 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:~~.

~~1. Coordinated care plans that provide health care services, including but not limited to health maintenance organization plans (with or without point-of-service option), plans offered by provider-sponsored organizations, and preferred provider plans;~~

~~2. Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and~~

~~3. Medicare Advantage private fee-for-service plans~~.

(v) “Medicare replacement coverage" means coverage that meets the definition in s. 600.03 (28p), Stats., as interpreted by sub. (2) (a), and that conforms to subs. (4), (4m), (4s),

(5s) and (7) “Medicare replacement coverage" includes Medicare cost ~~and Medicare Advantage plans~~policies.

SECTION 6. Ins 3.39 (3) (vg) and (vr), are created to read:

Ins 3.39 (3) (vg) “Medicare select issuer” means an issuer offering, or seeking to offer, a Medicare select policy or certificate.

(vr) “Medicare select policy" or “Medicare select certificate" mean, respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

SECTION 7. Ins 3.39 (3) (w) is amended to read:

Ins 3.39 (3) (w) “Medicare supplement coverage" 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), (5), (5m), (5s), (6), (30), ~~and~~ (30m), and (30s). “Medicare supplement coverage" includes Medicare supplement and Medicare select ~~plans~~policies but does not include coverage under Medicare Advantage ~~plans~~policies established under Medicare Part C or Outpatient Prescription Drug ~~plans~~policies established under Medicare Part D.

SECTION 8. Ins 3.39 (3) (wg), (wr), (zbm), (zcm), (zf) and (3g), are created to read:

Ins 3.39 (3) (wg) “Network provider," means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare select policy or certificate.

(wr) “Newly eligible” means a Medicare eligible person who attains age 65 on or after January 1, 2020, who has not participated in Medicare Part B prior to attaining age 65, and who was not entitled to benefits under Medicare Part A pursuant to ss. 226 (b) of 226A of the Social Security Act or s. 226 (a) of the Social Security Act prior to January 1, 2020.

(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.

(zf) “Type” means, when used in reference to a plan or policy, includes a Medicare supplement individual and group policy, and a Medicare select individual and group policy.

(3g) MEDICARE ELIGIBLE PERSON. (1) Generally, an individual who attains age 65 or older, individuals under the age of 65 with certain disabilities or individual with end-stage renal disease are eligible to enroll in Medicare. The date a person is first eligible for Medicare Part B or first elected Medicare Part A, establishes the coverage options that the person may be able to initially obtain. In addition to the provisions that apply to all Medicare supplement and Medicare cost policies or certificates, the following identifies the benefit and coverage subsections that have provisions tied to the date and year when a person is first eligible for Medicare Parts A and B.

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

(b) For persons first eligible for Medicare Part A and B on or after July 1, 2010, subs. (4m), (5m), (7), (14m), and (30m) and Appendices (2), (3), (4), (5), and (6) are applicable in addition to any provision in this section that generally pertains to Medicare eligible persons.

(c) 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 from person eligible prior to January 1, 2020. For these newly eligible persons, subs. (4s), (5s), (7), (14s), and (30s) and Appendices (2m), (3m), (4m), (5m), and (6m) are applicable in addition to any provision in this section that generally pertains to Medicare eligible persons.

(2) Medicare supplement and Medicare select policies are guaranteed renewable for life. Therefore, a Medicare eligible person can, at their choice, elect to receive benefits and coverage under a policy that may have fewer riders available. An insurer cannot require the Medicare eligible person to replace existing coverage with coverage reflecting recent changes including changes due to MACRA. This means that if a Medicare eligible person who is eligible

for Medicare prior to January 1, 2020, and elects the Medicare Part B medical deductible rider prior to January 1, 2020, upon renewal of the policy that person shall be eligible to continue to receive benefits from the Medicare Part B medical deductible rider in accordance with the terms of the policy even though the insurer can no longer market that rider. However, a Medicare eligible person who was first eligible for Medicare prior to January 1, 2020, but did not elect the Medicare Part B medical deductible rider cannot select that rider for the first time after January 1, 2020, as marketing of the Medicare Part B medical deductible rider is not permitted in accordance with MACRA.

SECTION 9. Ins 3.39 (4) (title) and (intro.), (a) (intro.) 4., 5., 7., 9., 10., 11., 12., and 18r., (b) (intro.), 1., 3., 5., 7., (c) (intro.) and 1., (e) (intro.) and 1., are amended to read:

Ins 3.39 (4) (title) MEDICARE SUPPLEMENT AND MEDICARE ~~REPLACEMENT~~ COST POLICY AND CERTIFICATE REQUIREMENTS FOR POLICIES AND CERTIFICATES WITH EFFECTIVE DATES PRIOR TO JUNE 1, 2010.

(4) (intro.) 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 with effective dates prior to June 1, 2010, as a Medicare supplement 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 complies with the following:

(4) (a) The policy or certificate shall provide the following:

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 policy shall not be cancelled or nonrenewed by the insurer on the grounds of deterioration of health. The policy may be cancelled only for nonpayment of premium or material misrepresentation. If the policy is issued by a health maintenance organization as defined by s. 609.01 (2), Stats., the policy may, in addition to the

above reasons, be cancelled or nonrenewed by the issuer if the insured moves out of the service area~~;~~.

7. Contains statements on the first page and elsewhere in the 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~~ that the policy or certificate is issued and ~~for which~~that it may be renewed. (~~the~~The renewal period cannot be less than the greater of the following: 3 months, the period for which the insured has paid the premium, or the period specified in the policy~~);~~.

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 font size ~~of which~~ 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 required by s. 632.84, Stats., and a provision describing any grievance rights required by s. 632.83, Stats., applicable to Medicare supplement and Medicare ~~replacement~~ cost policies~~; and~~.

18r. Reinstitution of such coverages: a. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

b. Shall provide for resumption of coverage that was in effect before the date of suspension in subd. 18. If the suspended Medicare supplement or Medicare cost policy provided coverage for outpatient prescription drugs, reinstitution 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~~; and~~.

(b) The outline of coverage for the policy or certificate~~.~~ shall comply with all 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~~;~~.

3. Is substituted to properly describe the 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 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, substantially in the format of sub. (11) of Appendix 1~~; and~~.

(c) Any rider or endorsement added to the policy or certificate shall 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~~; and~~.

(e) The anticipated loss ratio for any new policy form, that is, the expected percentage of the aggregate amount of premiums earned which will be returned to insureds in the form of

aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form shall comply with the following:

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;.

SECTION 10. Ins 3.39 (4m) is renumbered Ins 3.39 (3r) and Ins 3.39 (3r) (b), as renumbered, is amended to read:

3.39 (3r) (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.

SECTION 11. Ins 3.39 (4s) is renumbered Ins 3.39 (4m) and Ins 3.39 (4m) (title) and (intro.), (4m) (a) 3., 12., 21. b. and c., and 22., (4m) (b) 5. and 7., (4m) (c) (intro.) and 2., (d) and (e) (intro.), as renumbered, are amended to read:

Ins 3.39 (4m) (title) MEDICARE SUPPLEMENT AND MEDICARE ~~REPLACEMENT~~ COST POLICY AND CERTIFICATE REQUIREMENTS FOR POLICIES AND CERTIFICATES WITH EFFECTIVE DATES ON OR AFTER JUNE 1, 2010.

(intro.) 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 for delivery in this state on or after June 1, 2010, but no later than December 31, 2019, as a Medicare supplement or as a Medicare ~~replacement~~ cost policy or certificate, as defined in s. 600.03 (28p) (a) and (c), Stats., unless it complies with the following:

(a) 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).

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 required by s. 632.83, Stats., applicable to Medicare supplement and Medicare ~~replacement~~ cost policies or certificates.

21. b. 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 or Medicare cost policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D insureds 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.

c. Shall provide for resumption of the suspended Medicare Part B medical deductible coverage if the insured was enrolled prior to January 1, 2020, and the insurer offers a plan 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.

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

(b) 5. Is substantially in the format prescribed in Appendices ~~3 through 6~~3m, 4m, 5m, 6m, to this section for the appropriate category and printed in no less than 12-pint 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 selected coverage, substantially in the format of sub. (11) in Appendix ~~2~~2m to this section.

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

2. Added ~~After~~ after the date of policy or certificate issue~~, any rider or endorsement added to the policy or certificate~~ shall be agreed to in writing signed by the insured if 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.

(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:

SECTION 12. Ins 3.39 (4s) is created to read:

(4s) MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY AND CERTIFICATE REQUIREMENTS FOR POLICIES AND CERTIFICATES WITH EFFECTIVE DATES ON OR AFTER JANUARY 1, 2020. Except as explicitly allowed by subs. (5s) and (30s), no disability insurance policy or certificate shall relate its coverage to Medicare or be structured, advertised, marketed or issued for delivery in this state on or after January 1, 2020, as a Medicare supplement or as a Medicare cost policy or certificate, as defined in s. 600.03 (28p) (a) and (c), Stats., unless it complies with the following:

(a) The policy or certificate complies with the following:

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

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 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.

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. (5s) or (30s).

11. Contains text that is plainly printed in black or blue ink the size of which 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 required by s. 632.83, Stats., applicable to Medicare supplement and Medicare cost policies or certificates.

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 in force in this state shall contain benefits that duplicate benefits provided by Medicare.

18. A Medicare supplement policy or certificate 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 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.

21. Reinstitution of such coverages:

a. May not provide for any waiting period with respect to treatment of preexisting conditions.

b. 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 or Medicare cost policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D insureds 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.

c. Shall provide for resumption of the suspended Medicare Part B medical deductible coverage if the insured was enrolled prior to January 1, 2020, and the insurer offers a policy with Medicare Part B medical deductible coverage. If the insurer no longer offers a policy 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.

d. Shall provide for classification of premiums 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 that 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. (5s), (7) or (30s).

5. Is substantially in the format prescribed in Appendices 3s, 4s, 5s, and 6s 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. (5s) (d) and the optional coverage as set out in sub. (5s) (e), and the annual premiums for selected coverage, substantially in the format of sub. (11) in Appendix 2s to this section.

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 the following:

1. Shall be set forth 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 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 defined in sub. (5s) (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 2s to this section 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.

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

(f) For subsequent rate changes to the policy or certificate form, the issuer:

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

2. Includes in its filing 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 sub. (16) (d).

SECTION 13. Ins 3.39 (5m) (a) 2., 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 14. Ins 3.39 (5m) (b) and (c) are renumbered (5m) (a) 2. a. and b.:

SECTION 15. Ins 3.39 (5m) (e) is amended to read:

(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 16. Ins 3.39 (5s) is created to read:

Ins 3.39 (5s) MEDICARE SUPPLEMENT BENEFIT PLAN POLICY OR CERTIFICATE REQUIREMENTS FOR POLICIES AND CERTIFICATES WITH EFFECTIVE DATES ON OR AFTER JANUARY 1, 2020. (a) 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. Insurers shall not advertise, solicit, deliver or issue for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020.

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

(b) 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 as a Medicare supplement policy or certificate unless it complies with these benefit standards.

a. 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).

b. Benefit standards applicable to Medicare supplement policies and certificates with effective dates 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. (4s). 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:

1. The designation: MEDICARE SUPPLEMENT INSURANCE.

2. The 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."

(c) 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 (1) and (2), 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 disorder 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, each rider is priced separately, available for purchase separately at any time, subject to underwriting and the preexisting

limitation allowed in sub. (4s) (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. Separate riders, if offered, shall consist of the following:

1. Coverage of 100% of the Medicare Part A hospital deductible. The rider shall be designated: 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: 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 (1) and (2), Stats. The rider shall be designated as: ADDITIONAL HOME HEALTH CARE RIDER.

4. Medicare Part B Copayment or Coinsurance Rider. Under this option, 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 benefit 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 benefit, “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. (30s) (p), (r) and (s), may be offered in addition to Medicare benefits.

(g) For the Medicare supplement 50% Cost-Sharing plans, only the following:

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 is met as described in subd. 12.

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 is met as described in subd. 12.

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

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 is met as described in subd. 12.

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 is met as described in subd. 12.

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 meets the out-of-pocket limitation described in subd. 12.

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 the Medicare Supplement 25% Cost-Sharing plans, only the following:

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 is met as described in subd. 12.

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 is met as described in subd. 12.

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

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 is met as described in subd. 12.

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 is met as described in subd. 12.

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 meets the out-of-pocket limitation described in subd. 12.

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, the following:

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

2. Coverage for 100% of benefits described in pars. (d) and (e) 1., 3., 4., 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 of the U.S. Department of Health and Human Services 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.

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

SECTION 17. Ins 3.39 (6) (intro.), is amended to read.

Ins 3.39 (6) (intro.) 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 (5s) (d) 6., 9., and 14. If the issuer includes such a provision, the issuer shall:

SECTION 18. Ins 3.39 (7) (title), (a) (intro.), (b), (c), and (dm) 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 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 after January 1, 2005, and prior to June 1, 2010.

(b) (intro.) 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:

a. Be printed on, or attached to, the first page of the policy.

b. Have the following caption or title: **"RIGHT TO DISENROLL FROM PLAN."**

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 Medicare cost issuer, as defined in s. 600.03 (28p) (a) and (c), Stats., may offer an enhanced Medicare cost plan that contain the coverage contained in sub. (5) (c) 5., 6., 7., 8., 13., 15., 16., 17., and the riders described in sub. (5) (i)

(dm) For Medicare cost policies issued on or after June 1, 2010, 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 19. Ins 3.39 (7) (cs) and (ds), are created to read:

Ins 3.39 (7) (cs) For Medicare cost policies issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, each Medicare cost issuer, as defined in s. 600.03 (28p) (a) and (c), Stats., may offer an enhanced Medicare cost plan that includes; the coverage contained in sub. 16. and 17., the riders described in sub. (5s) (e), and other coverages as authorized by CMS.

(ds) For Medicare cost policies issued on or after January 1, 2020, shall comply with the outline of coverage listed in Appendix 2s. 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 2s 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. (5s).

SECTION 20. Ins 3.39 (8) (title), (a), (c), and (e), are amended to read:

Ins 3.39 (8) PERMISSIBLE MEDICARE SUPPLEMENT AND MEDICARE ~~REPLACEMENT~~ COST POLICY OR CERTIFICATE EXCLUSIONS AND LIMITATIONS

(a) The coverage set out in subs. (5), (5m), (5s), (7), (30), ~~and~~ (30m), and (30s), as applicable:

(c) The coverages set out in subs. (5), (5m), (5s), (7), (30), ~~and~~ (30m), and (30s), 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 may include other exclusions and limitations ~~which~~that are not otherwise prohibited and are not more restrictive than exclusions and limitations contained in Medicare.

SECTION 21. Ins 3.39 (13), (14) (a), (c) (intro.) 1. to 6., and (i), (14m) (a), (c) 1. to 6., and (i), are amended to read:

Ins 3.39 (13) Policies and certificates defined in sub. (2) (d), even if they are Medicare supplement policies as defined in s. 600.03 (28r), Stats., or Medicare ~~replacement~~ cost policies as defined in s. 600.03 (28p) (a) and (c), Stats., shall not be subject to either of the following:

Ins 3.39 (14) (a) Each issuer issuing policies or certificates with effective dates 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 and one group Medicare supplement policy 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, 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 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 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 carriers~~; and~~.

(i) No issuer may issue a Medicare supplement policy or certificate 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:

Ins 3.39 (14m) (title) OTHER REQUIREMENTS FOR POLICIES OR CERTIFICATES WITH EFFECTIVE DATES ON OR AFTER JUNE 1, 2010, AND PRIOR TO JANUARY 1, 2020.

(a) Each issuer issuing policies or certificates with effective dates 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 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 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 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 carriers~~; and~~.

(i) No issuer may issue a Medicare supplement policy or certificate 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 22. Ins 3.39 (14s) is created to read:

(14s) OTHER REQUIREMENTS FOR POLICIES OR CERTIFICATES WITH EFFECTIVE DATES ON OR AFTER JANUARY 1, 2020. **(a)** Each issuer issuing policies or certificates with effective dates on or after 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 policy or certificate form and one group Medicare supplement policy or certificate form with any of the accompanying riders permitted in sub. (5s) (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. 1395 ss), by complying with all of the following:

1. Accepting a notice from a Medicare carrier 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 carrier 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 carriers.

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

(d) Except as provided in subd. 1., 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.

1. 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.

2. An issuer that discontinues the availability of a policy or certificate form pursuant to subd. 1., shall not file for approval a new policy or certificate form of the same type 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.

3. This subsection shall not apply to the riders permitted in sub. (5s) (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 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 to an applicant 75 years of age or older, unless the applicant is subject to sub. (4m) 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 or certificate form and one group Medicare select policy or 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 with an effective date on or after January 1, 2020, issuers shall combine the Wisconsin experience of all policy or certificate forms of the same

type, individual or group, for the purposes 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. 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 23. Ins 3.39 (16) (c), (d) (intro.) and 3., and (e), (17), are amended to read:

Ins 3.39 (16) (a) Every issuer providing Medicare supplement ~~or 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 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), <u>(4m) (e), (4s) (e),</u> (14) (L), <u>(14m) (L), (14s) (L)</u> and this subsection, the loss ratio standards shall be:

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 where coverage is provided by a health maintenance organization shall not include any of the following:

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.

(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. (4) (g), (4m) (f), and (4s) (f) as applicable.

Ins 3.39 (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 24. 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 ~~or Medicare cost~~ 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 25. 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 ~~or Medicare cost~~ policy or certificate to an individual who is eligible for guaranteed issue sub. (34), calculated on a different basis of the commissions paid for the sale of a Medicare supplement ~~or Medicare cost~~ policy or certificate to an individual who is eligible for open enrollment sub. (3r).

SECTION 26. Ins 3.39 (22) (d), and (f) and 1., (23) (c) and (e), (24) (a), (25) (a), (b), and (c), and (26) (b), are amended to read:

Ins 3.39 (22) (d) If a Medicare supplement ~~or Medicare cost~~ 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."

Ins 3.39 (22) (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 or Medicare cost insurance policies or certificates in the format similar to Appendix 4 or Appendix 4m. The notice shall contain 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 or Medicare cost policy or certificate~~, and~~.

Ins 3.39 (23) (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 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).

Ins 3.39 (24) (a) Every issuer marketing Medicare supplement insurance coverage in this state, directly or through its producers, shall:

1. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

2. Establish marketing procedures to assure excessive insurance is not sold or issued.

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.

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."**

Ins 3.39 (25) (a) In recommending the purchase or replacement of any Medicare supplement 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 or Medicare ~~replacement~~ cost policy or certificate that will provide an individual more than one Medicare supplement or Medicare ~~replacement~~ cost policy or certificate is prohibited.

(c) An agent shall forward each application taken for a Medicare supplement 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.

Ins 3.39 (26) (a) On or before March 1 of each year, every issuer providing Medicare supplement or Medicare cost insurance coverage 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 or Medicare cost insurance policy or certificate:

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

2. Date of issuance.

3. Type of policy.

4. Company name and NAIC number.

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

6. Other information as requested by the commissioner.

(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.

SECTION 27. Ins 3.39 (27), (28) (c), (29) (a), are amended to read:

Ins 3.39 (27) If a Medicare supplement or Medicare cost policy or certificate replaces another Medicare supplement or Medicare cost policy or certificate, 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 or new Medicare cost policy for similar benefits to the extent such time was satisfied under the original policy or certificate. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate that has been in effect for at least 6 months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods,

elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

Ins 3.39 (28) (c) If a group Medicare supplement policy is replaced by another group Medicare supplement policy, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any ~~limitation~~exclusion for ~~pre-existing~~preexisting conditions that would have been covered under the group policy being replaced.

Ins 3.39 (29) (a) An issuer shall not deliver or issue for delivery a policy or certificate 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.

SECTION 28. Ins 3.39 (30) (b) and (30m) (b), are repealed.

SECTION 29. Ins 3.39 (30) (o), and (30m) (i) 1. and 8., (o), (q) are amended to read:

Ins 3.39 (30) (o) A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the ~~CMS~~ United States Department of Health and Human Services, for the purpose of evaluating the Medicare select program.

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.

(o) A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the ~~CMS~~ United States Department of Health and Human Services, for the purpose of evaluating the Medicare select program.

(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:

SECTION 30. Ins (30s) is created to read:

(30s) MEDICARE SELECT POLICIES AND CERTIFICATES. **(a)** 1. This subsection shall apply to Medicare select policies and certificates issued on or after January 1, 2020.

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

(b) The commissioner may authorize an issuer to offer a Medicare select policy or certificate, pursuant to this subsection and section 4358 of the Omnibus Budget Reconciliation Act of 1990, if the commissioner finds that the issuer has satisfied all of the requirements of this subsection.

(c) 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 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 that:

a. Such 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. 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. 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 both 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 such services 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 2 and 5 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 pursuant to 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. (4s) (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. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

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, a Medicare select issuer shall make available to each applicant for a Medicare select 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, which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such 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 pursuant to 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 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 such 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. (5s) (d).

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

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

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

5. Coverage for emergency care obtained outside of the United States as described in sub. (5s) (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. (4s) (a) 2., and may consist of the following:

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

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

(r) The Medicare Select 50% Cost-Sharing plans issued with an effective date 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 is met as described in subd. 12.

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 is met as described in subd. 12.

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

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 is met as described in subd. 12.

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 is met as described in subd. 12.

10. Coverage for 100% of the cost sharing for the benefits described in sub. (5s) (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 meets the out-of-pocket limitation described in subd. 12.

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 with an effective date on or after January 1, 2020, shall only contain the following 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 is met as described in subd. 12.

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 is met as described in subd. 12.

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

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 is met as described in subd. 12.

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 is met as described in subd. 12.

10. Coverage for 100% of the cost sharing for the benefits described in sub. (5s) (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 meets the out-of-pocket limitation described in subd. 12.

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. (5s) (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 31. Ins 3.39 (31) (a), (b) and (bm) are repealed and recreated to read:

(31) (a) Every issuer providing individual or group Medicare supplement, or individual or group Medicare select policies 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 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. Calculate the amount of refund or premium credit, if any.

5. A certification that the refund calculation is accurate.

SECTION 32. Ins 3.39 (34) (title), (a) 1., 2., (b) (title) and (intro.), (e) 4. and 5., are amended to read:

Ins 3.39 (34) (title) GUARANTEED ISSUE FOR MEDICARE ELIGIBLE PERSONS.

(a) 1. ~~Eligible~~Medicare eligible persons are those individuals described in sub. (3g), and 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 or Medicare cost policy, and where applicable, evidence of enrollment in Medicare Part D.

2. With respect to a Medicare eligible person, an issuer may not deny or condition the issuance or effectiveness of a Medicare supplement 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 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 or Medicare cost policy.

(b) (title) and (intro.) *~~Eligible~~Medicare eligible persons.* ~~An~~A Medicare eligible person is an individual described in any of the following subdivisions:

(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 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 with 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 33. Ins 3.39 (34) (ez) is renumbered (em) and amended to read:

Ins 3.39 (34) (em) *Products ~~to which~~ Medicare eligible persons are entitled to enroll on or after June 1, 2010.* The Medicare supplement, or Medicare cost policy or certificate ~~to which~~ that the Medicare eligible persons are entitled to enroll including and of the following ~~under~~:

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

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 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 34. Ins 3.39 (34) (es) is created to read.

Ins 3.39 (34) (es) *Products that Medicare eligible persons are entitled to enroll on or after January 1, 2020.* The Medicare supplement or Medicare cost policy or certificate that Medicare eligible persons are entitled to enroll into includes any of the following:

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

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. (5s) with any riders available or a Medicare select policy or certificate as defined in sub. (30s).

4. Paragraph (b) 7., is a Medicare supplement policy or certificate as described in sub. (5s) with any riders available or a Medicare select policy or certificate as defined in sub. (30s), 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 35. Ins 3.39 (35) (a) is amended to read:

Ins 3.39 (35) (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 36. Ins 3.39 Appendix 2 is renumbered 2m:

SECTION 37. Ins 3.39 Appendix 2s is created to read:

Ins 3.39 APPENDIX 2s

For policies delivered or issued 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 replacement insurance policy as defined in s. 600.03 (28p) (a) and (c), Stats., shall contain the following language: Medicare replacement 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 policies as defined 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 policies, as defined 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.

(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 38. Ins 3.39 Appendix 3 is renumbered Appendix 3m and 3m (title) and (subtitle) is 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 39. Ins 3.39 Appendix 3s, is created to read:

Ins 3.39 APPENDIX 3s

OUTLINE OF COVERAGE

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

(The designation and caption required by sub. (4s) (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 defined at sub. (5m) (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**	

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
	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 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 defined at sub. (5s) (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	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**	**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	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 40. Ins 3.39 Appendix 4 is renumbered 4m and 4m (title) is amended to read:

Ins 3.39 APPENDIX 4~~4~~m (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 41. Ins 3.39 Appendix 4s is created to read:

Ins 3.39 APPENDIX 4s

OUTLINE OF COVERAGE

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT 50% and 25% COST-SHARING PLANS

(The designation required by sub. (5s) (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") and 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	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 42. Ins 3.39 Appendix 5 is renumbered 5m and 5m (title) is amended to read:

Ins 3.39 APPENDIX ~~5~~5m

OUTLINE OF COVERAGE

SECTION 43. Ins 3.39 Appendix 5s is created to read:

Ins 3.39 APPENDIX 5s

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. (30s) (i) 8. and 9., or the designation required by sub. (30s) (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"), and 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	
HOSPICE CARE Available as long as your doctor certifies you are		All but very limited coinsurance or copayment for	$0 or [ ]% of coinsurance or copayments	☐

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
terminally ill and you elect to receive these services.		outpatient drugs and inpatient respite care		

** 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	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 44. 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 COVERAGE 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 standards. You must have been in a hospital for at least 3 days and enter the facility within 30 days after	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.		

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**
discharge.				
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 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 45. Ins 3.39 Appendices 6m and 6s are created to read:

Ins 3.39 APPENDIX 6m

[NOTICE OF CHANGE FOR OUTLINE OF COVERAGE]
[FOR APPLICANTS FIRST ELIGIBLE 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 & 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.		

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**
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				
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	

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**
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 6s

[NOTICE OF CHANGE FOR OUTLINE OF COVERAGE]
[FOR APPLICANTS NEWLY ELIGIBLE 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				
HOSPITALIZATIO N	All but $___ for the first 60 days/benefit	All but $___ for the first 60		

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**
Inpatient Hospital Services, Semi-Private Room & Board, Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room	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.	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 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	All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care $0 or [ ]% of coinsurance or		☐

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**
	copayments	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 25. 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 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 26. Ins 3.39 Appendices 8 and 9 are repealed.

SECTION 27. 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 in any long-term care policy, and life insurance-long-term care coverage and any Medicare replacement or supplement policy an internal procedure for benefit appeals.

(5) (intro.) REPORTS TO THE COMMISSIONER. An insurer offering a long term insurance policy or rider shall report to the commissioner by March 31 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 26. Ins 3.55 (5m) is created to read:

Ins 3.55 (5m) An insurer offering a Medicare replacement or supplement policy shall report to the commissioner by March 1 of each year a grievances experience report consistent with s. Ins 18.06 (2).

SECTION 27. EFFECTIVE DATE. A rule is effective on the first day of the month commencing after the date of publication in accordance with s. 227.22, Stats.

Dated at Madison, Wisconsin, this _____ day of _____, _____.

JP Wieske
Deputy Commissioner