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CLEARINGHOUSE REPORT TO AGENCY

[THIS REPORT HAS BEEN PREPARED PURSUANT TO S. 227.15, STATS. THIS IS A REPORT ON A RULE AS ORIGINALLY PROPOSED BY THE AGENCY; THE REPORT MAY NOT REFLECT THE FINAL CONTENT OF THE RULE IN FINAL DRAFT FORM AS IT WILL BE SUBMITTED TO THE LEGISLATURE. THIS REPORT CONSTITUTES A REVIEW OF, BUT NOT APPROVAL OR DISAPPROVAL OF, THE SUBSTANTIVE CONTENT AND TECHNICAL ACCURACY OF THE RULE.]

CLEARINGHOUSE RULE **00–133**

AN ORDER to renumber Ins 3.39 (34) (b) 2. b., c. and d.; to amend Ins 3.39 (3) (cm) and (34) (b) 2., 5. a. and 6. and (c) 1.; to repeal and recreate Ins 3.39 (21) (f) and (34) (b) 2. a.; and to create Ins 3.39 (4) (a) 18p. and (34) (b) 2. b. and f. and (c) 3., relating to revising requirements for insurers offering medicare + choice, medicare supplement and replacement plans in order to comply with recent changes in federal laws.

Submitted by **OFFICE OF THE COMMISSIONER OF INSURANCE**

09–11–00 RECEIVED BY LEGISLATIVE COUNCIL.
10–03–00 REPORT SENT TO AGENCY.

RS:GAA:jal;rv

LEGISLATIVE COUNCIL RULES CLEARINGHOUSE REPORT

This rule has been reviewed by the Rules Clearinghouse. Based on that review, comments are reported as noted below:

1. STATUTORY AUTHORITY [s. 227.15 (2) (a)]

   Comment Attached YES ☐ NO ☑

2. FORM, STYLE AND PLACEMENT IN ADMINISTRATIVE CODE [s. 227.15 (2) (c)]

   Comment Attached YES ☑ NO ☐

3. CONFLICT WITH OR DUPLICATION OF EXISTING RULES [s. 227.15 (2) (d)]

   Comment Attached YES ☐ NO ☑

4. ADEQUACY OF REFERENCES TO RELATED STATUTES, RULES AND FORMS [s. 227.15 (2) (e)]

   Comment Attached YES ☐ NO ☑

5. CLARITY, GRAMMAR, PUNCTUATION AND USE OF PLAIN LANGUAGE [s. 227.15 (2) (f)]

   Comment Attached YES ☐ NO ☑

6. POTENTIAL CONFLICTS WITH, AND COMPARABILITY TO, RELATED FEDERAL REGULATIONS [s. 227.15 (2) (g)]

   Comment Attached YES ☐ NO ☑

7. COMPLIANCE WITH PERMIT ACTION DEADLINE REQUIREMENTS [s. 227.15 (2) (h)]

   Comment Attached YES ☐ NO ☑

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CLEARINGHOUSE RULE 00–133

Comments

[NOTE: All citations to "Manual" in the comments below are to the Administrative Rules Procedures Manual, prepared by the Revisor of Statutes Bureau and the Legislative Council Staff, dated September 1998.]

2. Form, Style and Placement in Administrative Code

a. In SEC. 2, the material in parentheses should be set apart with commas or be placed in an explanatory note. [See s. 1.01 (6), Manual.] This same problem also occurs in SEC. 11 of the rule.

b. Throughout the rule, references are made to "sections" of the Social Security Act. However, references to federal laws should utilize the U.S. Code reference as has been done correctly in SEC. 1 of the rule. See SECS. 2, 4, 11 and 12 of the rule for examples of this problem.

c. In s. Ins 3.39 (21) (f), the notations "par." and "pars." should be replaced by the notation "sub." Also, the word "defined" should be replaced by the word "described," since the term in question already is defined in s. Ins 3.39 (3) (cm).

d. In s. Ins 3.39 (34) (b) 2., the word "below" should be replaced by the phrase "in subpars. a. to f."

e. In SEC. 5, the reference to "part" should be replaced by a reference to "Part C of Medicare." Also, the notation "; or" should be replaced with a period.

f. In SEC. 7, "such" should be replaced by "the." [See s. 1.01 (9) (c), Manual.]

g. In SEC. 10, "par." should be inserted before "(b) 2.," and "(a)" in par. (b) 2. f. i. and before "(b) 2. f. i." and "(a)" in par. (b) 2. f. ii. However, it should be noted that subdivision paragraphs, i.e., (b) 2. f., may not be further divided. [See s. 1.03 (6), Manual.] The sentences of subpar. f. can be combined into one subparagraph.

h. In s. Ins 3.39 (34) (c) 3., the word "defined" should be replaced by the word "described."

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

RENUMBERING, AMENDING, REPEALING AND CREATING AND CREATING A RULE

The Wisconsin Office of the Commissioner of Insurance proposes an order to renumber ss. Ins 3.39 (34) (b) 2. b., Ins 3.39 (34) (b) 2. c., Ins 3.39 (34) (b) 2. d.; to amend ss. Ins 3.39 (3) (cm), 3.39 (34) (b) 2., 3.39 (34) (b) 5. a., 3.39 (34) (b) 6, 3.39 (34) (c) 1.; to repeal and recreate ss. Ins 3.39 (21) (f), 3.39 (34) (b) 2. a.; and to create ss. Ins 3.39 (4) (a) 18p., 3.39 (34) (b) 2. b., 3.39 (34) (b) 2. f., 3.39 (34) (c) 3., relating to revising requirements for insurers offering Medicare + Choice, Medicare supplement and replacement plans in order to comply with recent changes in federal laws.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 600.01(2), 601.41(3), 601.42, 628.34(12), 628.38, 632.81, Stats.

Statutes interpreted: ss. 600.03 (28p) and (28r), 632.81, Stats.

These changes bring the Wisconsin regulations in compliance with changes in federal law under the Balanced Budget Refinement Act and the Ticket To Work And Work Incentives Improvement Act of 1999 that amend section 1882 of the Social Security Act which governs Medicare Supplement Insurance. Further, these changes are also necessary to conform with the National Association of Insurance Commissioners (NAIC) Medicare Supplement Insurance Minimum Standards Model Act.

The changes specifically address the guaranteed issue provisions and the suspension of benefits and premiums. The changes also include the following: reference to a new federal program, Program of All-Inclusive Care for the Elderly (PACE), created under the Social Security Act; provisions for notice and election rights of those whose Medicare + Choice plan is terminated; modification to the notice that is provided to applicants describing Part B benefits within Medicare Supplement policies; and clarification regarding the sale of Medicare + Choice plans by full-time employes.

Section 1: Section Ins 3.39 (3) (cm) is amended to read:

Ins 3.39 (3) (cm) "Medicare + Choice" plan means a plan of coverage for health benefits under Medicare Part C as defined in ~~Section 1859 in Title IV, Subtitle A, Chapter 1 of P.L. 105-33~~ 42 U.S.C. 1395w-28 (b) (1), and includes:

Section 2: Section Ins 3.39 (4) (a) 18p. is created to read:

Ins 3.39 (4) (a) 18p. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for the period provided by federal regulation) at the request of the policyholder if the policyholder 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 certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder 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 entitlement.

Section 3: Section Ins 3.39 (21) (f) is repealed and recreated to read:

Ins 3.39 (21) (f) Sale of Medicare + Choice plans, as ~~defined~~ described in par. (7) (b), by full-time, salaried employes of insurers are not subject to pars. (21) (a) and (b).

Section 4: Section Ins 3.39 (34) (b) 2. is amended to read:

Ins 3.39 (34) (b) 2. The individual is enrolled with a Medicare + Choice organization under a Medicare + Choice plan under part C of Medicare, and any of the following circumstances ~~apply:~~ apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to those

described ~~below~~ that would permit discontinuance of the individual's enrollment and such provider if such individual were enrolled in a Medicare + Choice plan:

Section 5: Section Ins 3.39 (34) (b) 2. a. is repealed and recreated to read:

Ins 3.39 (34) (b) 2. a. The certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; ~~or~~ .

Section 6: Section Ins 3.39 (34) (b) 2. b. is renumbered to 3.39 (34) (b) 2. c.

Section 7: Section Ins 3.39 (34) (b) 2. b. is created to read:

Ins 3.39 (34)(b) 2. b. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuance of such plan.

Section 8: Section Ins 3.39 (34) (b) 2. c. is renumbered to 3.39 (34) (b) 2. d.

Section 9: Section Ins 3.39 (34) (b) 2. d. is renumbered to 3.39 (34) (b) 2. e.

Section 10: Section Ins 3.39 (34) (b) 2. f. is created to read:

Ins 3.39 (34) (b) 2. f.

i. An individual described in (b) 2. may elect to apply (a) by substituting, for the date of termination of enrollment, the date on which the individual was notified by the Medicare + Choice organization of the impending termination or discontinuance of the Medicare + Choice plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.

ii. In the case of an individual making the election in (b) 2. f. i the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under (a) shall only become effective upon termination of coverage under the Medicare + Choice plan involved.

Section 11: Section Ins 3.39 (34) (b) 5. a. is amended to read:

Ins 3.39 (34) (b) 5. a. The individual was enrolled under a ~~medicare~~ Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare + Choice organization under a Medicare + Choice plan under part C of Medicare, any eligible organization under a contract under Section 1876 (~~medicare~~ Medicare risk or cost), any similar organization operating demonstration project authority, any PACE program under section 1894 of the Social Security Act, an organization under an agreement under section 1833 (a)(1)(A) (health care prepayment plan), or a ~~medicare~~ Medicare Select policy; and

Section 12: Section Ins 3.39 (34) (b) 6. is amended to read:

Ins 3.39 (34) (b) 6. The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare + Choice plan under part C of Medicare, or in a PACE program under section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

Section 13: Section Ins 3.39 (34) (c) 1. is amended to read:

Ins 3.39 (34)(c)1. Par. (b) 1., 2., 3., and 4 ~~and 6~~, is a ~~medicare~~ Medicare supplement policy as defined in sub. (5) along with any riders available or a ~~medicare~~ Medicare Select policy as defined in sub. (30). except the Outpatient Prescription Drug rider defined in sub. (5) (i) 7.

Section 14: Section Ins 3.39 (34) (c) 3. is created to read:

Ins 3.39 (34) (c) 3. Par. (b) (6) is a Medicare supplement policy as ~~defined~~ described in sub. (5) along with any riders available or a Medicare Select policy as defined in sub. (30).

Section 15: Section Ins 3.39 appendix 1 is amended to read:

MEDICARE SUPPLEMENT POLICIES– PART B BENEFITS

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

Once you have been billed $100 of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Note: ~~add~~ Add the following text in bold or contrasting color if the plan is a ~~Medicare~~ Medicare Supplement High Deductible Plan as defined in (5) (k) or (m): This high deductible plan offers benefits after one has paid a calendar year [$1500] 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 prescription drug deductible or] the plan's separate foreign travel emergency deductible.

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	[AFTER YOU PAY A $1500 DEDUCTIBLE] PLAN PAYS	YOU PAY
MEDICAL EXPENSES. Eligible expenses for physician's services, in-patient and out-patient medical services and supplies at a hospital, physical and speech therapy, ambulance, and outpatient psychiatric care.	Initial ($) deductible After initial deductible	$0 Generally 80%	Nothing Or OPTIONAL PART B DEDUCTIBLE RIDER* Generally 20% of Medicare eligible charge or, in case of hospital outpatient department services under a prospective payment system, applicable copayments and OPTIONAL MEDICARE PART B EXCESS CHARGES RIDER*	
Outpatient Prescription Drugs	Initial $6,250 deductible	$0 Generally does not cover prescription drugs.	80% of charges over $6,250 and OPTIONAL MEDICARE OUT-PATIENT PRESCRIPTION DRUG RIDER*	
Blood		80% of costs except nonreplacement fees (blood deductible) for first 3 pints (after $___ deductible / calendar year)	20% of all eligible costs and the first 3 pints in each calendar year	
Part B policy limits per calendar year			No limit	

Clinical Laboratory Services – Blood Tests For Diagnostic Services		100%	$0	

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

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

(a) Nursing home care costs beyond what is covered by Medicare and the 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 40 visits mandated by s. 632.895 (2), Stats.

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

(d) Outpatient prescription drugs.

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

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

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

(h) Waiting period for pre-existing conditions.

(i) Limitations on the choice of providers or the geographical area served (if applicable).

(j) Usual, customary, and reasonable limitations.

(k) For Medicare + Choice policies, list any benefit required by Wisconsin law which is not covered by this policy.

(6) CONSPICUOUS STATEMENTS AS FOLLOWS:

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

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

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

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

(10) A description of the review and appeal procedure for denied claims.

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

MEDICARE SUPPLEMENT PREMIUM INFORMATION

Annual Premium

$ ( ) BASIC MEDICARE SUPPLEMENT COVERAGE

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT POLICY

Each of these riders may be purchased separately.
(Note: Only optional coverages provided by rider shall be listed here.)

$ ( ) 1. Part A deductible
100% of Part A deductible
$ ( ) 2. Additional home health care
An aggregate of 365 visits per year including those covered by Medicare
$ ( ) 3. Part B deductible
100% of Part B deductible
$ ( ) 4. Part B excess charges
Difference between the Medicare eligible charge and the amount charged by the provider which shall be no greater than the actual charge or the limited charge allowed by Medicare, whichever is less.
$ ( ) 5. Outpatient prescription drug charges
At least 50% of the charges after a deductible of $ ____ (no more than $250) to a maximum benefit of $3,000 per year.
$ ( ) 6. Foreign travel rider
After a deductible not greater than $250, covers at least 80% of expenses associated with emergency medical care received outside the U.S.A. during the first 60 days of a trip with a 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 ~~Supplement~~ Medicare Supplement High Deductible Plan 1 and 2 shall modify the outline to reflect the benefits which are contained in the policy and the optional or included riders.)

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

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

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

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

Section 16: These changes first applies to policies issued on or after January 1, 2001.

Section 17: Effective Date. This rule will take effect on the first day of the month after publication, as provided in s. 227.22 (2) (intro), Stats.

Dated at Madison, Wisconsin, this 8 day of September 2000.

Connie L. O'Connell
Commissioner of Insurance