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CLEARINGHOUSE RULE 04-121

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 October 2002.]

2. Form, Style and Placement in Administrative Code

a. Section Ins 3.39 (3) includes definitions for various terms that include substantive requirements. Definitions should state what a term means or includes for purposes of s. Ins 3.39 and should not include substantive requirements. [See s. 1.01 (7), Manual.]

Moreover, s. Ins 3.39 (3) is not following the National Association of Insurance Commissioners (NAIC) model which separates its section on definitions that apply for the purpose of the regulation [Section 4 of NAIC Model Regulation 651] from the section that imposes substantive requirements on insurers by specifying that no policy or certificate may be advertised, solicited, or issued for delivery as a Medicare supplement policy or certificate unless the policy or certificate contains certain definitions, such as the definition of "accident," "accidental injury," "accidental means," "benefit period," "Medicare," "physician," and "sickness" that conform to the NAIC model language [Section 5 of NAIC Model Regulation 651]. Section Ins 3.39 (3) confuses the two concepts by combining them into one definition provision.

For example, s. Ins 3.39 (3) (x) indicates that "'physician' shall not be defined more restrictively than as defined in the Medicare program." This does not define "physician" for purposes of s. Ins 3.39, but is a requirement that applies to an insurer with respect to Medicare supplement policies. A separate subsection should be created to require that policies include definitions that meet certain parameters; these substantive provisions should not be included in the general definition provision.

Moreover, the rule defines terms (such as "accidental means" in s. Ins 3.39 (3) (b)) that are not used in s. Ins 3.39. Section Ins 3.39 (3) should include only definitions of terms that are used in s. Ins 3.39.

b. The use of capitalization should be reviewed in the rule. For example, in s. Ins 3.39 (3) (b), "Accidental Injury" and "Accidental Means" and in s. 3.39 (3) (j), "Health Care Expense" should not be capitalized. [See s. 1.01 (4), Manual.]

Also, the capitalization of "Medicare Select" is changed in several provisions, such as s. Ins 3.39 (30) (m) 2. and (n) (intro.). These changes are not necessary as many other provisions of s. Ins 3.39 have this term capitalized, along with the names of other policies.

In the fourth chart in Appendix 1 under sub. (4), capitalization is inconsistent, especially with respect to the phrase "Medicare approved amounts" which is capitalized three different ways. This entire chart should be reviewed for capitalization errors.

c. References to various federal acts or sections of acts should be reviewed and changed to use the U.S. Code citation. If reference to a public law or named federal act is desired, it could be included in a note. [See s. 1.07 (3) (a), Manual.] (Section Ins 3.39 (3) (i) provides an alternative acceptable approach.) Examples of provisions to review include: s. Ins 3.39 (3) (h) 1. c., d., e., h. and j. and 5. a. and b. and (34) (b) 2., 5. a. and 6.

Another approach that might be useful in certain instances, particularly with respect to references to the "Medicare Prescription Drug, Improvement and Modernization Act of 2003" as used in s. Ins 3.39 (4) (a) 21., (22) (i) and (29) (b) would be to define that term in s. Ins 3.39 (3) (and perhaps include the acronym MMA for it), include the USC sections in the definition, and then use the defined term or acronym in the text of s. Ins 3.39. This comment also applies to the acronyms PPS and CMS.

d. In s. Ins 3.39 (3) (h) 3. (intro.) and 4. (intro.), "shall not include" should be changed to "does not include." Also, in par. (h) 2. h., the phrase "Other similar insurance coverage" should be replaced by the phrase "Insurance coverage similar to that described in subpars. a. to g." [See also par. (h) 3. c.]

e. Section Ins 3.39 (3) (l) should be changed to Ins 3.39 (3) (L). [See s. 1.03 (4), Manual.]

f. In the treatment clause and text of SECTION 3, the reference to "18r. (b)" should be changed to "18r. b." [See s. 1.03 (5), Manual.]

g. The ending punctuation of the subdivisions of s. Ins 3.39 (4) (a) is inconsistent; some use a semicolon, while others use a period. In general, all subunits should end with a period to facilitate future insertions and the introductory material should specify if all or any of the provisions apply. [See s. 1.03 (intro.), Manual.] All of the provisions in s. Ins 3.39 should be reviewed to assure a consistent approach to any provision being modified. For example, s. Ins 3.39 (4) (b) 1. should end with a period instead of a semicolon to be consistent with other subdivisions in that paragraph.

h. In s. Ins 3.39 (4) (a) 18m. and 18r. b., the reference to "par. (18)" should be changed to "subd. 18."

i. Section Ins 3.39 (4) (a) 20. c. attempts to have further subdivisions of i. and ii. However, this is not permitted. [See s. 1.03 (6), Manual.] All of this material should be included as a sentence in s. Ins 3.39 (4) (a) 20. c.

j. In s. Ins 3.39 (4) (a) 21., the reference to "subd. (5) of this subsection" should be changed to "subd. 5." [See s. 1.07 (2), Manual.]

k. New material should be underscored and immediately follow material that is being removed and shown as stricken-through. [See s. 1.06 (1), Manual.] Thus, s. Ins 3.39 (4m) (b) should be shown as: "~~This~~ Except as provided in pars. (c) and (d) and sub. (34), this section…." (Also, note the revised references to pars. (c) and (d).)

Other instances in which inserted material inappropriately precedes over-stricken material include s. Ins 3.39 (23) (a) 4., (30) (p) (intro.) and (34) (b) 5. a., the second paragraph under "Medicare Part A" of Appendix 1 under sub. (4), and the second paragraph of "Medicare Supplement Policies, Part B Benefits" of Appendix 1.

l. If an acronym is to be used, it should be defined, rather than included as a parenthetical reference in a rule. [See s. 1.01 (8), Manual.] For example, in s. Ins 3.39 (5) (c) 12., (n) 4. and (o) 4. "prospective payment system (PPS)" should be defined. Other examples include s. Ins 3.39 (5) (c) 14., along with several references to a PACE provider. Also, in the treatment clause for SECTION 6, the word "and" should be inserted before the notations "15." and "(m)."

Also, s. Ins 3.39 (7) (a) (intro.) refers to the Centers for Medicare and Medicaid Services (CMS) and the acronym is used in s. Ins 3.39 (7) (c) and (22) (j). The term and acronym should be defined in s. Ins 3.39 (3).

m. In s. Ins 3.39 (5) (k) (intro.) and (m) (intro.), the new material being added "that may be issued…thereafter" should be shown as underscored. [See s. 1.06 (1), Manual.] Also, in the treatment clause and text "(m)" should be shown as "(m) (intro.)" and "(k) (intro.)" should be shown as "(k) (intro.)." Several other provisions do not include the period following "(intro.)."

n. In s. Ins 3.39 (5) (n) 8. and (o) 8., (23) (a) 4., (30) (q) 8. and (r) 8., and (34) (c) 1. a., the parentheses should be changed to commas. [See s. 1.01 (6), Manual.]

o. In s. Ins 3.39 (23) (a) 6., the title to the booklet should not be underscored as it is not being amended.

p. In s. Ins 3.39 (23) (a) 6., it appears that the comment about losing coverage and guaranteed issue should be in a subdivision (that is, 7. that precedes the title "[Questions]") since the content of the comment does not relate to a question.

q. In SECTION 15, the treatment clause should delete the phrase "as renumbered."

r. In SECTIONS 17 and 18, the titles in s. Ins 3.39 (27) and (29), respectively, should be reproduced even though they are not being changed. [See s. 1.05 (3) (c), Manual.]

s. In the treatment clause and text of SECTION 19, "(30) (i) 1. b. 3." should be changed to "(30) (i) 3." and the word "and" should be inserted before the notation "(p)." Also, in sub. (30) (i) 3., the notation "par." should be replaced by the notation "sub."

t. SECTION 20 provides that s. Ins 3.39 (30) (q) is renumbered (s). SECTION 22 then amends that provision. The renumbering and amendment should occur in one SECTION.

u. The treatment clause of SECTION 23 should be changed to delete the reference to s. Ins 3.39 (34) (b) 1r. as it is not being amended. Also, the references in the treatment clause and text to s. Ins 3.39 (34) (b) 2. and 4. should be changed to "2. (intro.)" and "4. (intro.)."

v. In the text of SECTION 25, "(intro.)" should be inserted following "s. Ins 3.39 (34) (c) 1."

w. Section Ins 3.39 (34) (c) 5. is being created in SECTION 27. Therefore, its material should be shown in plain print, without any overstriking or underscoring. [See s. 1.06 (1), Manual.] The term "~~sixty-day~~ 60 period" should be changed to "60-day period."

x. It is not necessary to include the note at the end of s. Ins 3.39 (34) (f) 2. since it is not being amended.

y. In Appendix 1 following the title, the reference should be to "sub. (4) (b) 4." [See s. 1.07 (2), Manual.]

z. Material being deleted should be shown as over-stricken and added material underscored. [See s. 1.06 (1), Manual.] The following comments apply to the appendices to s. Ins 3.39:

1) In the second column, first row of the first chart in Appendix 1 under sub. (4), "Beyond the additional 365 days" should be changed to: "Beyond ~~150~~ the additional 365 days."

2) The double-asterisked notice at the end of the first chart in Appendix 1 under sub. (4) should be underscored.

3) In the third column, second row of the first chart in Appendix 1 under sub. (4), "All approved amounts" should be changed to: "~~100% of costs~~ All approved amounts."

4) In sub. (5) (b) of Appendix 1, "[For Medicare select policies only.]" should be underscored.

aa. SECTION 33 specifies that s. Ins 3.39 may be enforced under various statutes. However, SECTION 33 does not propose including its provisions in s. Ins 3.39. Thus, it appears that this statement is being included for informational purposes. If so, it should be included in the analysis, rather than as a numbered section of the proposed order. However, if it is intended to be included in s. Ins 3.39, it should be assigned a subsection number in s. Ins 3.39.

3. Conflict With or Duplication of Existing Rules

a. The rule repeals the definition of "Medicare + Choice plan" currently defined in s. Ins 3.39 (3) (cm) due to its replacement with Medicare Advantage. However, ss. Ins 9.01 (12), 9.35

(4), 9.39 (4), 18.02 (1) and 18.10 (3) continue to refer to the "Medicare + Choice plan" and should also be amended.

Also, the cross-reference in s. Ins 9.01 (12) to "s. Ins 3.39 (3) (cm)" is incorrect after the repeal and recreation of s. Ins 3.39 (3) and should be amended.

b. Sections Ins 18.02 (1) and 18.10 (3) refer to definitions in current s. Ins 3.39 (3) (f) and (g). After the repeal and recreation of s. Ins 3.39 (3), these cross-references are incorrect, thus, these provisions also should be amended.

c. The second sentence of s. Ins 3.39 (29) (b) requires that, beginning January 1, 2006, issuers must provide to all renewing insureds an approved rider deleting coverage for outpatient prescription drugs. However, s. Ins 3.39 (4) (a) 20. a. indicates that if a current policyholder who does ***not*** enroll in Medicare Part D has a policy in existence prior to January 1, 2006, with benefits for outpatient prescription drugs, then the policy must be renewed at the option of the policyholder. These provisions are inconsistent with respect to insureds who do not enroll in Medicare Part D.

Further, the concept of a rider on a newly issued policy "deleting" coverage seems to be inappropriate if the newly issued policy did not include drug coverage. It appears that the second sentence in s. Ins 3.39 (29) (b) should be modified to indicate that its requirement applies only until new business forms that comply with MMA have been approved for that company.

d. Current s. Ins 3.39 (5) (j) refers to the benefits specified in "sub. (30) (p) and (q)." Because SECTION 20 is renumbering sub. (30) (q), the provision in s. Ins 3.39 (5) (j) should be amended to change the cross-reference. Also, it appears that cross-references to newly created s. Ins 3.39 (30) (q) and (r) should be included.

e. The last sentence of the third paragraph of the text of "Medicare Part A" in Appendix 1 under sub. (4) discusses "excess charges" and states that the person is responsible for paying the difference between the amount charged by the provider and the amount paid by Medicare. This statement seems to be inconsistent with s. Ins 3.39 (5) (c) 12. which indicates that, for Medicare hospital inpatient expenses, the provider must accept the issuer's payment as payment in full and may not bill the insured for any balance.

Was this sentence in Appendix 1 intended for the Medicare Part B Supplement provision?

f. The fourth chart in Appendix 1 under sub. (4) outlines Medicare Select Policies—Part B Benefits. The fourth column, second and third rows, indicate that for the remainder of Medicare approved amounts, the plan pays generally 10%. While this may be accurate for individuals who purchase the 50% plan described in s. Ins 3.39 (30) (q), it would not be accurate for individuals who purchase the 25% plan described in s. Ins 3.39 (30) (r). With respect to the latter, the plan would pay generally 15%, not 10%. The chart should be amended to clarify this, or separate charts should be created to describe the par. (q) plan and the par. (r) plan.

g. In sub. (5) (b) of Appendix 1, it is unclear why the number of home health care visits mandated by s. 632.895 (2), Stats., was changed from 40 to 365. Section 632.895 (2) (d), Stats., requires coverage for 40 visits, and s. 632.895 (2) (e), Stats., requires that optional coverage for

365 aggregate visits be available if requested. Thus, the amendment to sub. (5) (b) will not be universally accurate.

h. Appendix 4 of current s. Ins 3.39 was not amended. However, its reference to the "Health Care Financing Authority" in the last paragraph should have been amended to reflect the new name. Also, since part of the function of Appendix 4 is to provide notice of change in Medicare, it appears that it would be useful to amend it to reflect changes in Medicare under the MMA.

4. Adequacy of References to Related Statutes, Rules and Forms

a. In the analysis, it appears that the statutory authority section also should list ss. 625.16, 628.38, 632.73, and 632.76, Stats.

b. The statutes interpreted provision in the analysis refers to s. 632.895 (6) and (9), Stats. However, these provisions are not included in the list of statutes interpreted in s. Ins 3.39 (1) (c).

c. In s. Ins 3.39 (3) (h) 1. i., the reference to "a public health plan as defined in federal regulation" should be changed to specify the federal regulation.

Similarly, in s. Ins 3.39 (3) (h) 2. h., the reference to "similar insurance coverage, specified in federal regulations" should be changed to specify the federal regulations. This comment also applies to s. Ins 3.39 (3) (h) 3. c. A similar comment applies to s. Ins 3.39 (5) (n) 8. and (o) 8. and (30) (q) 8. and (r) 8.

d. Section Ins 3.39 (3) (v) specifies that "nursing home coverage" means coverage as described in s. Ins 3.46 (3). However, s. Ins 3.46 (3) simply provides many definitions for purposes of s. Ins 3.46. A more accurate cross-reference should be provided.

e. In s. Ins 3.39 (5) (k) (intro.) and (m) (intro.), the phrase "renewed thereafter" is confusing in light of s. Ins 3.39 (4) (a) 20. Would it be more accurate to change the phrase "renewed thereafter" to "renewed thereafter in accordance with sub. (4) (a) 20."? Otherwise, there is no clear indication in s. Ins 3.39 (5) (k) and (m) that the renewal provision applies only to those who have not enrolled in Part D of Medicare.

f. In s. Ins 3.39 (5) (n) 5. and 6., "sub. (i)" should be changed to "subd. 11."

g. Section Ins 3.39 (5) (n) 11. and (o) 11. refer to a deductible amount, and s. Ins 3.39 (30) (q) 11. and (r) 11. refer to an annual limitation of a certain amount "indexed each year by the appropriate inflation adjustment specified by the Secretary [of Health and Human Services]." It would be useful if a citation were given to the authority under which the Secretary specifies this adjustment amount and where information can be obtained as to the amount of the out-of-pocket limitation in years subsequent to 2006. The latter information could be included in a note following each provision directing the reader to a posting on the Office of the Commissioner of Insurance's (OCI) website.

5. Clarity, Grammar, Punctuation and Use of Plain Language

a. The third sentence of Item 3 of the analysis indicates that the rule implements the requirement that "by January 1 2006, Medicare supplemental, replacement, cost-sharing, select and Advantage plans cannot offer a Medicare Part D prescription drug, except as permitted by s. 632.895 (6), Stats. [drugs to treat diabetes], due to the fact that Wisconsin is one of three states that has been granted a waiver from being required to offer the standard plans as described by CMS." The following comments apply to this sentence:

1) A comma should be inserted following "January 1."

2) "Supplemental" should be changed to "supplement."

3) "Stat." should be changed to "Stats."

4) This sentence refers to "Medicare…replacement, *cost-sharing*, select…" [emphasis added] plans. It is not clear what a "cost-sharing" plan is in contrast to the other plans listed. Moreover, it is not clear what the reference to a "cost-sharing" plan means in the relating clause or in Item 4 of the analysis. The term "cost-sharing" is not used in s. Ins 3.39. In contrast to this third sentence, the prior sentence refers to "Medicare…replacement, *cost*, select…" [emphasis added] plans. "Cost" plans are referred to in s. Ins 3.39 (7). Thus, it appears that references to "cost-sharing" should be changed to "cost." However, it appears that a Medicare cost plan is a subset of the category of Medicare replacement policies under s. Ins 3.39 (7) (a) 1. or is synonymous with that term. If there is no difference between a replacement plan and a cost plan, one of these terms should be selected and used in the relating clause and analysis.

5) The sentence incorrectly indicates that these Medicare-related policies cannot offer a prescription drug benefit because Wisconsin is a waiver state. However, the prohibition applies because of federal law, not because of the waiver granted to Wisconsin. This should be clarified.

6) It appears that the reference to "Medicare Part D" in the third sentence should be deleted in the phrase "offer a Medicare Part D prescription drug benefit." Also, it would be more accurate to refer to "prescription drug plan insurance products" without reference to "Medicare Part D" in the first sentence of Item 3.

b. In the first sentence of Item 4 of the analysis, the word "and" should precede "select plans." Also, it would be useful to the reader if the third sentence of Item 4 specified that the "requirement for prescription drugs" is a requirement for prescription drugs to treat diabetes.

c. In Item 4 of the analysis, the acronyms "NAIC" and "MMA" are used but not explained until Item 5. The name of the act and the reference to National Association Insurance Commissioners in Item 5 should be moved to Item 4.

d. In the second paragraph of Item 5 of the analysis, the second sentence indicates that Medigap policies are purchased to cover Medicare deductibles and "selected services that Medicare does not cover." It appears that reference to covering Medicare coinsurance—especially Part B coinsurance—should be included, as that is a significant component of what is

covered by Medigap policies, rather than Medicare deductibles and non-covered services. Also, the last sentence of that paragraph indicates that Medigap policies are designed to supplement "only those benefits covered by the Medicare program." This contradicts the second sentence, which indicates that some Medigap policies cover service that Medicare does not cover. This inconsistency should be corrected.

e. The second sentence of the third paragraph of Item 5 of the analysis indicates that the rule would create "two high deductible Medicare supplement policies basic Medicare supplement policies and Medicare select policies." Punctuation is needed in this phrase to clarify its meaning. Also, it is not clear that the rule creates "basic Medicare supplement policies." These already exist under the current rule in s. Ins 3.39 (3) (c).

f. The first sentence of the last paragraph of Item 5 of the analysis is incomplete as it ends with "meet the requirements of."

g. In the last sentence of the last paragraph of Item 5 of the analysis, "a insurance" should be changed to "an insurance." Also, "for" should be inserted before the phrase "reviewing advertising materials."

h. In Item 6 of the analysis, the second paragraph should conclude with a period.

i. In Number 3 in the listing in the fifth paragraph of Item 6 of the analysis, in the phrase "when Medicare Part D *becomes comes into effect*" [emphasis added], the emphasized portion should be changed to either "becomes effective" or "comes into effect." Also, Number 4 in the listing should end with a period, rather than a comma.

j. In Number 3 in the listing in the last paragraph of Item 6 of the analysis, "December 30, 2004" should be changed to December 30, 2005." Also, "sales" should be changed to "sale."

k. Wisconsin statutes refer to "worker's compensation," not "workers' compensation." Section Ins 3.39 (3) (b) 2., (h) 2. d. and (bb) 2. should be changed to reflect this.

l. In the last sentence of Item 11 of the analysis, a period should be inserted after the word "Wisconsin" and the word "again" should be replaced by the word "Again."

m. In s. Ins 3.39 (3) (h) 1. f., "Indian Service Health Service" should be changed to "Indian Health Service."

n. In s. Ins 3.39 (3) (h) 2. (intro.), "include one or more, or any combination of, the following:" should be changed to "any of the following:".

o. In s. Ins 3.39 (3) (q) (intro.), the phrase "any of the following" should be inserted after the word "includes." The following subdivisions all should conclude with a period.

p. In s. Ins 3.39 (3) (s), "all person who qualify" should be changed to "a person who qualifies."

q. Section Ins 3.39 (3) (z) defines "replacement" as certain transactions wherein a new Medicare supplement policy is to be purchased and other insurance is terminating. However, there is the separate concept of a Medicare replacement policy in s. Ins 3.39 (7), which replaces Medicare. It appears that it would be more accurate to state in s. Ins 3.39 (3) (z) that

"'Replacement' means, other than when used to refer to an authorized Medicare replacement policy, any transaction…."

r. In s. Ins 3.39 (3) (z), it appears that "company" should be changed to the defined term "issuer."

s. Section Ins 3.39 (5) (c) 12. indicates that for certain Medicare Part A eligible expenses, "the provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance." It does not appear that Wisconsin statutes provide OCI with the authority to impose this requirement on providers. If the provision is included because that is what federal law requires, information to this effect could be included in a note. However, the provision does not appear to be enforceable by OCI as a matter of state law. This comment also applies to s. Ins 3.39 (5) (n) 4. and (o) 4. and (30) (q) 4. and (r) 4.

t. The following comments apply to s. Ins 3.39 (5) (c) 14.:

1) In the first sentence, the commas setting off the phrase "not covered…physician" should be deleted.

2) In the first sentence, the meaning of "attending physician," as opposed to simply a physician is not clear. What criteria are used to determine if a physician is "attending"?

3) In the first sentence, the difference between "immunizations" and "tetanus and diphtheria booster" is not clear. Are tetanus and diphtheria boosters considered to be immunizations? If so, the first reference to immunizations should be to immunizations other than tetanus and diphtheria. If the intention is to limit coverage for tetanus and diphtheria boosters to once every 10 years, this should be stated without parentheses. [See s. 1.01 (6), Manual.]

4) In the third sentence, should the reference to a "minimum of $120 annually" be changed to a "maximum of $120 annually"? See Section 8. C. (9) (b) of NAIC Model Regulation 651.

5) In the third sentence, should the reference to the amount of the annual benefit just refer to preventive health care services? As currently drafted, it appears to apply to both preventive health services and in-hospital private duty nursing services since both are referred to in the first sentence.

u. In s. Ins 3.39 (5) (i.) 7., "grater" should be changed to "greater."

v. The amendment to s. Ins 3.39 (5) (k) (intro.) adds the phrase "that may be issued prior to December 31, 2005 or renewed thereafter." This suggests that while the Medicare Supplement High Deductible Plan can be renewed after December 31, 2005 (although, presumably, only in accordance with s. Ins 3.39 (4) (a) 20.), it cannot be issued after that date. Is this correct? If so, this should be explicitly stated.

If so, the change does not appear to have been required by the MMA, other than removal of drug coverage (except for drugs to treat diabetes) from the plan, which the proposed order does. The MMA provides for additional supplement plans, not the elimination of existing supplement plans (other than removal of drug coverage from them). If the supplement plan in s.

Ins 3.39 (5) (k) cannot be offered on or after January 1, 2006 (except for renewals), this is a significant development that should be included in the analysis.

However, if the Medicare Supplement High Deductible Plan can be issued on or after January 1, 2006 if drug coverage is removed, s. Ins 3.39 (5) (k) (intro.) should be revised to make this clear.

w. The plans in s. Ins 3.39 (5) (n) and (o) are labeled respectively as "Medicare Supplement High Deductible Plan 50%" and "Medicare Supplement High Deductible Plan 25%." However, there is no specific language explaining what the deductible is, only coverage is listed. Arguably, there is not a deductible associated with either plan. Rather, for each plan, there appears to be coverage at various specified percentages (which presumably means coinsurance payments at those percentages, but this is not clearly stated), up to an annual out-of-pocket limitation, at which point payment is at 100%. If this is correct, it is unclear why the plans have "deductible" in their titles. If this is not correct, then the provisions should carefully explain what the deductible is, for example, using language patterned after s. Ins 3.39 (5) (k) 2., 3. and 4. which explain the deductible under the Medicare Supplement--High Deductible Plan.

A similar comment applies to s. Ins 3.39 (30) (q) and (r), relating to Medicare Select High Deductible Plans 50% and 25%, respectively, which do not explicitly state what the deductible is.

x. It is unclear why s. Ins 3.39 (5) (n) 9. and (o) 9. are worded differently with respect to coverage for the Medicare Part B deductible. Was a difference intended? If not, the wording should be the same to eliminate ambiguity and confusion. This comment also applies to s. Ins 3.39 (30) (q) 9. compared to sub. (30) (r) 9.

y. It is unclear why s. Ins 3.39 (5) (n) 11. and (o) 11. are worded differently with respect to the out-of-pocket annual limitation. Was a difference intended? If not, the wording should be the same to eliminate ambiguity and confusion. This comment also applies to s. Ins 3.39 (30) (q) 11. compared to sub. (30) (r) 11.

z. It is confusing that the plan in s. Ins 3.39 (5) (o) is referred to as a "25%" plan, rather than a "75%" plan since the coverage is 75%. This comment also applies to s. Ins 3.39 (30) (r).

aa. The rule is adding paragraphs to s. Ins 3.39 (5). However, current s. Ins 3.39 (5) (intro.) does not make clear the relationship between the existing or proposed paragraphs.

bb. In s. Ins 3.39 (5) (n) 7. and (o) 7. and (30) (q) 7. and (r) 7., it appears that "eligible expenses and respite care" should be changed to "eligible expenses for hospice care and respite care."

cc. In s. Ins 3.39 (5) (n), and similar provisions, the introductory material in subds. (5) to (7) appear to be unnecessary and should be deleted.

dd. In s. Ins 3.39 (5) (n) and (o) and (30) (q) and (r), some subdivisions refer to "coverage of" a certain percentage and other subdivisions refer to "coverage for" a certain percentage. The difference in the terms is confusing. One term should be selected and used consistently.

ee. Section Ins 3.39 (7) (a) (intro.) provides that an insurer that has a cost contract must meet the standards in s. Ins 3.39 (4) and (5) but further indicates that the commissioner may, at

the request of an issuer, approve variations of the coverage under s. Ins 3.39 (5). The standards by which the commissioner evaluates such a request are not specified in this provision.

ff. In the form following s. Ins 3.39 (23) (a) 6., the following comments apply:

1) In Question 2, the colon preceding the question mark should be deleted.

2) In Question 3. a., it is not clear that the reader will understand the acronyms "HMO" and "PPO." Those phrases should be written out and followed by the acronym.

3) In Question 3. c., "Was this" should be changed to "Is this."

4) In Question 5. a., a comma should be inserted following "If so." Also, it may be useful to change "company" to "insurance company" to avoid the applicant's listing the name of the employer referred to in Question 5. (intro.). Also, Question 5. (intro.) asks only about "health insurance." Should this question be expanded to also solicit information about individuals who had health care coverage through an employer's self-funded plan, rather than simply health "insurance"?

gg. The first sentence of s. Ins 3.39 (29) (b) requires an insurer to file certain riders and amendments "with the commissioner in the state in which the policy or certificate is issued." If this provision just applies to policies or certificates issued in Wisconsin, should this just require filing with the commissioner without reference to other states?

hh. In s. Ins 3.39 (30) (n) 2., quotation marks are inserted around the term "significant benefit." To be consistent, they should also be inserted around the same term in s. Ins 3.39 (30) (m) 2.

ii. Section Ins 3.39 (30) (q) (intro.) and (r) (intro.) requires that a plan contain the "following benefits." However, neither s. Ins 3.39 (30) (q) 1. nor (r) 1., specify a benefit but, rather, concern the name. These provisions should be included in the introductory language.

jj. In s. Ins 3.39 (30) (q) 11., "$4000" should be changed to "$4,000."

kk. In the last sentence of s. Ins 3.39 (30) (s), it appears that "offered by issuance" should be changed to "offered for issuance."

ll. In s. Ins 3.39 (34) (b) 1r., the reference to "employee welfare plan" should be changed to the defined term "employee welfare benefit plan." Also in that provision, it is not clear what the phrase "or program" means in the phrase "Medicare Advantage plan or program." The defined term in s. Ins 3.39 (3) (q) is "Medicare Advantage plan," and that defined term should be used consistently.

mm. In s. Ins 3.39 (34) (b) 8., "individual eligible" should be changed to "individual is eligible" and the word "is" should be inserted before the word "covered."

nn. In s. Ins 3.39 (34) (c) 4., "4. b., 4. c." should be changed to "4. b. or c."

oo. In the treatment clause of SECTION 27, the comma should be deleted.

pp. In Appendix 1, the first item in the "Notice" provision should be labeled as "(1)."

qq. The first and second charts in Appendix 1 under sub. (4) relate to Medicare Supplement policies and apparently address Medicare Supplement policies under s. Ins 3.39 (5) (c), (k), (m), (n) and (o). The charts and their explanations of what Medicare pays and what the plan pays are very difficult to follow with respect to how the high deductible is calculated, especially for the plans under sub. (5) (n) and (o). For example, the note preceding the Medicare Part A chart discusses the out-of-pocket annual limit but indicates that it applies to the items or services noted "in the chart" (that is, the Part A chart) and does not indicate that the out-of-pocket limit also applies to the Part B services in the second chart. Also, plans under sub. (5) (n) and (o) have different percentage payments (50% versus 75%), but this is not reflected in the charts. Also, it is not clear that all of the elements of a Medicare Supplement under sub. (5) (c) are adequately described in the charts.

It may be useful to have separate charts for the different types of supplement plans and more clearly explain the deductibles in these charts so that it is easier to compare the plans.

rr. In the first column, fifth row of the first chart in Appendix 1 under sub. (4), an asterisk should follow "Home health care."

ss. In the third paragraph of text under "Medicare Select Part A" in Appendix 1 under sub. (4), "Medicare Supplement High Deductible Plan" should be changed to "Medicare Select High Deductible Plan."

tt. In the first column, first row of the third chart (Medicare Select Part A) in Appendix 1 under sub. (4), the asterisk should be changed to a double asterisk, or else the double asterisk to which it refers should be changed to a single asterisk.

uu. The fourth column, last row of the third chart in Appendix 1 under sub. (4) indicates that, for home health care, the plan pays for 365 visits. Is this supposed to refer to 365 total when aggregated with Medicare if the person bought the home health care rider under s. 632.895 (2) (e), Stats.? If so, this should be clarified. Also, the fourth column, last row of the first chart (Medicare Supplement Part A) in Appendix 1 indicates that, for home health care, the plan pays for 40 visits or the optional rider. It is not clear why the first chart (Medicare Supplement Part A) and the third chart (Medicare Select Part A) differ on this point.

Section 632.895 (2) (d) and (e), Stats., provides for the 40 visits and requires offering the optional aggregated 365 visits. However, the Supplement High Deductible Plans 50% and 25% in s. Ins 3.39 (5) (n) and (o) and the Select Plans in s. Ins 3.39 (30) (q) and (r) do not specifically refer to home health care and, thus, do not appear to provide or offer these benefits, even though these benefits are referred to in the charts in the Appendix. This inconsistency should be clarified.

vv. The fourth chart (Medicare Select Part B) in Appendix 1 under sub. (4) indicates that for "Preventive Benefits for Medicare covered services," Medicare pays "Generally [ ]% or more of Medicare Approved amounts," and the plan pays the "Remainder of Medicare approved amounts." Is there a maximum amount that Medicare will pay for preventive services? Should the second chart (Medicare Supplement Part B) in Appendix 1 under sub. (4) contain a comparable provision for preventive benefits since such services are included in the supplement plans described in s. Ins 3.39 (5) (n) and (o)?

ww. The triple asterisk note for the fourth chart in Appendix 1 under sub. (4) indicates that the person is responsible for paying excess charges (that is, the difference between the amount charged and the amount Medicare approved). Is this a correct statement if the provider has accepted Medicare assignment? If not, this exception should be explained.

xx. In sub. (5) (k) of Appendix 1, a period should be inserted at the end of the sentence.

yy. In sub. (6) of Appendix 1, it would be useful to indicate how "Medicare & You" can be obtained.

zz. In the last paragraph of sub. (11) of Appendix 1, "WITH" should be changed "THAT"; "THISE" should be changed to "THESE"; and "SUPPLMENT" should be changed to "SUPPLEMENT."

aaa. Appendix 5 was amended to provide notice to a person replacing a Medicare supplement or Medicare Advantage policy with a Medicare supplement policy. However, it appears that it also should provide notice to a person replacing a Medicare supplement or Medicare Advantage policy with a Medicare Advantage policy.

bbb. Following the first paragraph in the "Statement to Applicant by Issuer, Agent" in Appendix 5, one of the references to "Additional benefits" should be deleted.

ccc. In all of the disclosure statements in Appendix 8, in the third bullet point under "Before You Buy This Insurance," the person is advised to "contact your state insurance department or state senior insurance counseling program." Does this statement apply to persons outside Wisconsin? If not, it would be more useful to provide contact information for OCI. Even if it does apply to persons outside Wisconsin, it would be useful to include a note such as: "For Wisconsin residents, contact the Office of the Commissioner of Insurance at…."

ddd. In the disclosure statements in pars. (cL), (g) and (gL) of Appendix 8, it appears that the phrase "Medicare pays benefits" should be changed to "Medicare pays extensive benefits." This would make the language consistent with the language currently in those paragraphs and also reflect the language in pars. (a), (aL), (b), (bL) and (c) of Appendix 8. If this change is not made, the word "extensive should be shown as over-stricken in current pars. (cL), (g) and (gL).