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ARCHIVES DIVISION
MARY BETH HERKERT
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

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CHAPTER 836
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

FILING CAPTION: Adoption of requirements for sale of Medicare Supplement plans on or after January 1, 2020

EFFECTIVE DATE: 09/01/2018

AGENCY APPROVED DATE: 08/22/2018

CONTACT: Karen Winkel
503-947-7694
karen.j.winkel@oregon.gov

350 Winter St NE
Salem,OR 97301

Filed By:
Karen Winkel
Rules Coordinator

RULES:
836-052-0114, 836-052-0119, 836-052-0141, 836-052-0143, 836-052-0144

AMEND: 836-052-0114

NOTICE FILED DATE: 05/31/2018

RULE SUMMARY: Clarifying applicability of exhibits to OAR 836-052-0160.

CHANGES TO RULE:

836-052-0114
Applicability and Scope ¶

(1) Except as otherwise specifically provided in OAR 836-052-0134, 836-052-0140, 836-052-0144, 836-052-0145, 836-052-0160 and 836-052-0185, 836-052-0103 to 836-052-0194 apply to the following Medicare supplement policies and certificates issued under group Medicare supplement policies, as follows:¶
(a) All Medicare supplement policies delivered or issued for delivery in this state on or after July 1, 1992; and¶
(b) All certificates issued under group Medicare supplement policies and delivered or issued for delivery in this state on or after July 1, 1992.¶
(2) Except as otherwise specifically provided in OAR 836-052-0134, 836-052-0140, 836-052-01544, 836-052-0160, and 836-052-0185, on or after September 1, 1993, 836-052-0103 to 836-052-0194 apply to Medicare supplement policies and certificates issued under group Medicare supplement policies that are made subject to 836-052-0103 to 836-052-0194 because of amendments to the definition of "Medicare supplement policy" in ORS 743.680 and OAR 836-052-0119.¶
(3) A prepayment plan offered by a health maintenance organization under which the health maintenance organization and competitive medical plans provides Medicare services under the authority of Title XVIII Part C of the Social Security Act or Section 1876 of the federal Social Security Act (42 U.S.C. section 1395 et seq.) is not subject to OAR 836-052-0103 through 836-052-0194. The health maintenance organization and competitive medical plans must file with the Director, for information purposes, a copy of the Medicare contract forms and rates that the plan or health maintenance organization uses in this state, and the marketing and sales materials

used therewith.¶
(4) OAR 836-052-0103 to 836-052-0194 do not apply to an issued policy under a demonstration project specified in 42 U.S.C. sec. 1395ss (g)(1).¶
(5) OAR 836-052-0103 to 836-052-0194 do not apply to a policy or contract of one or more employers or labor organizations; or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof; for employees or former employees, or a combination thereof; or for members or former members, or a combination thereof, of the labor organizations.¶
(6) OAR 836-052-0103 to 836-052-0194 are effective on August 1, 2005. Insurers may continue using current forms, or may make changes to current forms if offering Plan K or L, as appropriate, through 2005. Insurers may offer any authorized plan upon approval by the Director of the Department of Consumer and Business Services.¶
(7) The changes to OAR 836-052-0145 and 836-052-0151 effective on February 17, 2011 apply to all new Medicare supplement policies or certificates issued on or after July 1, 2011. The changes to 836-052-0145 and 836-052-0151 effective on February 17, 2011 apply to all existing 1990 Standardized Medicare supplement benefit plans and all 2010 Standardized Medicare supplement benefit plans policies or certificates renewed on or after January 1, 2012. The changes to the Exhibits to 836-052-0160 effective on February 17, 2011 apply to all Medicare supplement policies or certificates issued on or after July 1, 2011.¶
(8) The changes to the Exhibits to OAR 836-052-0160 apply to all Medicare supplement policies or certificates effective on or after January 1, 2020.
Statutory/Other Authority: ORS 731.244, 743.682
Statutes/Other Implemented: ORS 743.010, 743.683

AMEND: 836-052-0119

NOTICE FILED DATE: 05/31/2018

RULE SUMMARY: To define “newly eligible” Medicare beneficiaries.

CHANGES TO RULE:

836-052-0119
Definitions ¶

As used in OAR 836-052-0103 to 836-052-0194:¶
(1) "Applicant" means:¶
(a) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits;¶
(b) In the case of a group Medicare supplement policy, the proposed certificate holder.¶
(2) "Bankruptcy" occurs when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.¶
(3) "Certificate" means any certificate delivered or issued for delivery under a group Medicare supplement policy.¶
(4) "Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.¶
(5) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no break in coverage greater than 63 days.¶
(6)(a) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:¶
(A) A group health plan;¶
(B) Health insurance coverage;¶
(C) Part A or Part B of Title XVIII of the Social Security Act (Medicare);¶
(D) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;¶
(E) Chapter 55 of Title 10 United States Code (CHAMPUS);¶
(F) A medical care program of the Indian Health Service or of a tribal organization;¶
(G) A state health benefits risk pool;¶
(H) A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);¶
(I) A public health plan as defined in federal regulation; and¶
(J) A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).¶
(b) "Creditable coverage" does not include one or more, or any combination of the following:¶
(A) Coverage only for accident or disability income insurance, or any combination thereof;¶
(B) Coverage issued as a supplement to liability insurance;¶
(C) Liability insurance, including general liability insurance and automobile liability insurance;¶
(D) Workers' compensation or similar insurance;¶
(E) Automobile medical payment insurance;¶
(F) Credit-only insurance;¶
(G) Coverage for on-site medical clinics; and¶
(H) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other medical benefits.¶
(c) "Creditable coverage" does not include the following benefits if they are provided under a separate policy, certificate or contact of insurance or are otherwise not an integral part of the plan:¶
(A) Limited scope dental or vision benefits;¶
(B) Benefits for long-term care, nursing home care, home health care, community based care, or any combination

thereof; and¶
(C) Such other similar, limited benefits as are specified in federal regulations.¶
(d) "Creditable coverage" does not include the following benefits if offered as independent noncoordinated benefits:¶
(A) Coverage only for a specified disease or illness; and¶
(B) Hospital indemnity or other fixed indemnity insurance.¶
(e) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:¶
(A) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;¶
(B) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and¶
(C) Similar supplemental coverage provided to coverage under a group health plan.¶
(7) "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).¶
(8) "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.¶
(9) "Insurance Policy" includes a subscriber contract or a prepayment contract of a health care service contractor and a policy or contract of a fraternal benefit society.¶
(10) "Issuer" includes insurers, fraternal benefit societies, health care service plans, health maintenance organizations as that term is defined in ORS 750.005, health care service contractors as that term is defined in 750.005, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.¶
(11) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.¶
(12) Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C.1395w-28(b)(1), and includes:¶
(a) Coordinated care plans that provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;¶
(b) Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and¶
(c) Medicare Advantage private fee-for-service plans.¶
(13) "Medicare Supplement Policy" means a group or individual insurance policy or a subscriber contract, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. section 1395ss(g)(1) that is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare Supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under sec. 1833(a)(1)(A) of the Social Security Act.¶
(14) "Newly eligible" means those individuals who become eligible for Medicare due to age, disability or end-stage renal disease on or after January 1, 2020.¶
(15) "Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer.¶
(15~~6~~) "Pre-Standardized Medicare supplement benefit plan," means a group or individual policy of Medicare supplement insurance issued prior to July 1, 1992.¶
(16~~7~~) "Secretary" means the Secretary of the United States Department of Health and Human Services.¶
(17~~8~~) "1990 Standardized Medicare supplement benefit plan," means a group or individual policy of Medicare supplement insurance issued on or after July 1, 1992 and with an effective date of coverage prior to June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date that are not

replaced by the issuer at the request of the insured.¶
(1~~8~~9) "2010 Standardized Medicare supplement benefit plan," means a group or individual policy of Medicare supplement insurance issued with an effective date of coverage on or after June 1, 2010.¶
~~[Publications: Publications referenced are available from the agency.]~~
Statutory/Other Authority: 743.682, ORS 731.244~~, 743.682~~
Statutes/Other Implemented: ORS 743.010, 743.683

AMEND: 836-052-0141

NOTICE FILED DATE: 05/31/2018

RULE SUMMARY: To clarify plans that can be offered to persons who became eligible for Medicare prior to January 1, 2020.

CHANGES TO RULE:

836-052-0141
Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates with an Effective Date of Coverage on or After June 1, 2010 ¶

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivere~~3~~d, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare supplement benefit plan for sale with an effective date for coverage on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates with an effective date for coverage before June 1, 2010 remain subject to the requirements of OAR 836-052-0133.¶
(1)(a) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in OAR 836-052-0132(2).¶
(b) If an issuer makes available any of the additional benefits described in OAR 836-052-0132(3) or offers standardized benefit Plans K or L as described subsections (5)(h) and (i) of this rule, then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic core benefits as described in subsection (a) of this section, a policy form or certificate form containing either standardized benefit Plan C as described in subsection (5)(c) of this rule or standardized benefit Plan F as described in subsection (5)(e) of this.¶
(2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in subsection (6) of this rule and OAR 836-052-0139.¶
(3) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this rule and conform to the definitions in OAR 836-052-0119. Each benefit plan must be structured in accordance with the format provided in 836-052-0132(2) and (3); or, in the case of plans K or L, in subsections (5)(h) and (i) of this rule and list the benefits in the order shown. For purposes of this rule, "structure, language, and format" means style, arrangement and overall content of a benefit.¶
(4) In addition to the benefit plan designations required in section (3) of this rule, an issuer may use other designations to the extent permitted by law.¶
(5) The content of the 2010 Standardized Medicare supplement benefit plans must be as follows:¶
(a) Standardized Medicare supplement benefit Plan A shall include only the basic core benefits as defined in OAR 836-052-0132 (2).¶
(b) Standardized Medicare supplement benefit Plan B shall include only the following: The basic core benefit as defined in OAR 836-052-0132(2); plus 100 percent of the Medicare Part A deductible as defined in 836-052-0132(3)(a).¶
(c) Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined OAR 836-052-0132(2); plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and Medically necessary emergency care in a foreign country, each as defined in OAR 836-052-0132(3)(a), (c), (d) and (f).¶
(d) Standardized Medicare supplement benefit Plan D shall include only the following: The basic core benefit as defined in OAR 836-052-0142(2), plus 100 percent of the Medicare Part A deductible skilled nursing facility care, and medically necessary emergency care in an foreign country each as defined in 836-052-0132(3)(a)(c) and (f).¶
(e) Standardized Medicare supplement regular Plan F shall include only the following: The basic core benefit as

defined in OAR 836-052-0132(2), plus 100 percent of the Medicare Part A deductible, the skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country each as defined in 836-052-132(3)(a), (c), (d), (e) and (f).¶
(f) Standardized Medicare supplement Plan F with high deductible shall include only the following: 100 percent of covered expenses following the payment of the annual deductible set forth in paragraph (B) of this subsection.¶
(A) The basic core benefit as defined in OAR 836-052-0132(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country each as defined in 836-052-0132(3)(a), (c), (d), (e) and (f).¶
(B) The annual deductible in Plan F with high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the standardized Medicare supplement regular Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually from 1999 according to the method prescribed 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.¶
(g) Standardized Medicare supplement benefit Plan G shall include only the following: The basic core benefit as defined in OAR 836-052-0132(2) of this regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country each as defined in 836-052-0132(3)(a), (c), (e) and (f). Effective January 1, 2020, the standardized benefit plans described in OAR 836-052-0144(1)(d) (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020. ¶
(h) Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:¶
(A) Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;¶
(B) Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;¶
(C) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;¶
(D) Medicare Part A Deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in paragraph (J) of this subsection;¶
(E) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance 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 paragraph (J) of this subsection;¶
(F) Hospice Care: Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph (J) of this subsection;¶
(G) Blood: Coverage for 50 percent under Medicare Part A or B, of the reasonable cost of the first three 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 paragraph (J) of this subsection;¶
(H) Except for coverage provided in paragraph (I) of this subsection, coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in paragraph (J) of this subsection;¶
(I) Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays

the Part B deductible; and¶
(J) Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.¶
(i) Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:¶
(A) The benefits described in section (5)(h)(A)(B)(C) and (I) of this rule;¶
(B) The benefit described in section (5) (h)(D)(E)(F)(G) and (H) of this rule, but substituting 75 percent for 50 percent; and¶
(C) The benefit described in section (5)(h)(J) of this rule, but substituting $2000 for $4000.¶
(j) Standardized Medicare supplement Plan M shall include only the following: The basic core benefit as defined in OAR 836-052-0132(2), plus 50 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country each as defined in 836-052-0132(3)(b), (c) and (f).¶
(k) Standardized Medicare supplement Plan N shall include only the following: The basic core benefit as defined in OAR 836-052-0132(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country each as defined in 836-052-0132(3)(a), (c) and (f), with copayments in the following amounts:¶
(A) The lesser of $20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit including visits to medical specialists; and¶
(B) The lesser of $50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.¶
(6)**:** With the prior approval of the Director of the Department of Consumer and Business Services, 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. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.
Statutory/Other Authority: ORS 743.683
Statutes/Other Implemented: ORS 743.010, 743.683

AMEND: 836-052-0143

NOTICE FILED DATE: 05/31/2018

RULE SUMMARY: To include the 2020 plans as an option for guaranteed issue under the birthday rule Exhibit to OAR 836-052-0160 to reflect the adoption of 836-052-0144 and the amendments to 836-052-0114, 836-052-0119, 836-052-0141 and 836-052-0143.

CHANGES TO RULE:

836-052-0143
Annual Opportunity to Select Another Medicare Supplement Policy or Certificate ¶

(1) For the purposes of this rule, for 1990, 2010, and 20~~1~~20 Medicare Supplement Plans, "same or lesser benefits" means a policy or certificate of the same or lower benefit level as indicated on a chart available on the website of the ~~Insurance Divis~~Division of Financial Regulation of the Department of Consumer and Business Services.¶
(2) Beginning on a person's birthday and for 30 days after the person's birthday, a person enrolled in a Medicare supplement policy may cancel the person's existing Medicare supplement policy or certificate and purchase or select another Medicare supplement policy or certificate with the same or lesser benefits to replace the existing Medicare supplement policy or certificate. An issuer may not deny or condition the issuance or effectiveness, nor discriminate in the pricing of the replacement policy or certificate on the basis of health status, claims experience, receipt of health care or medical condition of the applicant.¶
(3) This rule does not apply to Medicare supplement policies or certificates issued or delivered before January 1, 1990.
Statutory/Other Authority: ORS 731.244, ORS 743.010, 743.680 - 743.689
Statutes/Other Implemented: ORS 743.010, 743.683, 743.684

ADOPT: 836-052-0144

NOTICE FILED DATE: 05/31/2018

RULE SUMMARY: Specifying Medicare Supplement plans available to newly eligible Medicare beneficiaries.

CHANGES TO RULE:

836-052-0144
Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or after January 1, 2020.
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards to be applicable to all Medicare supplement policies delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020 remain subject to the requirements of OAR 836-052-0103 to 836-052-0194.¶
(1) Benefit Requirements. The standards and requirements of OAR 836-052-0141 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020 with the following exceptions:¶
(a) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in OAR 836-052-0141(5)(c) but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.¶
(b) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in OAR 836-052-0141(5)(e) but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.¶
(c) Standardized Medicare supplement benefit plans C, F and F With High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.¶
(d) Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in OAR 836-052-0141(5)(f) but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible. ¶
(e) The reference to Plans C or F contained in OAR 836-052-0141(1)(b) is deemed a reference to Plans D or G for purposes of this section.¶
(2) Applicability to Certain Individuals. This section, OAR 836-052-0144, applies to only individuals that are newly eligible for Medicare on or after January 1, 2020:¶
(a) By reason of attaining age 65 on or after January 1, 2020; or¶
(b) By reason of entitlement to benefits under Part A pursuant to section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.¶
(3) Guaranteed Issue for Eligible Persons. For purposes of OAR 836-052-0142, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G With High Deductible) respectively that meet the requirements of OAR 836-052-0144.¶
(4) Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in OAR 836-052-0144(1)(d) above may be offered to any individual who was

eligible for Medicare prior to January 1, 2020 in addition to the standardized plans described in OAR 836-052-0141(5).
Statutory/Other Authority: ORS 731.244 , ORS 743.683
Statutes/Other Implemented: ORS 743.683, ORS 743.010