JUN 28 2001

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott McCallum, Governor
Connie L. O'Connell, Commissioner

Wisconsin.gov

June 22, 2001

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HONORABLE JUDITH ROBSON
SENATE CO-CHAIRPERSON
JOINT COMM FOR REVIEW OF ADM RULES
SOUTH STATE CAPITOL RM 15
MADISON WI 53702

Re: Section Ins 3.39, Wis. Adm. Code, relating to Medicare Supplement and Replacement Plans

Clearinghouse Rule No. 00-133

Dear Senator Robson:

I am enclosing a copy of this proposed rule that has been submitted to the presiding officers of the legislative houses under s. 227.19 (2), Wis. Stat. A copy of the report required under s. 227.19 (3), Wis. Stat., is also enclosed.

Sincerely,

Connie L. O'Connell

Connie L. O'Connell
Commissioner

CLO:JW
Attachment: 1 copy rule & legislative report

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE REPEALING, RENUMBERING, RENUMBERING AND AMENDING, AMENDING, REPEALING AND RECREATING, AND CREATING A RULE

The Wisconsin Office of the Commissioner of Insurance proposes an order to repeal ss. Ins 3.39 (7) (b), (c) and (g), 3.39 (21) (f), to renumber ss. Ins 3.39 (7) (f), 3.39 (34) (b) 2. b., 3.39 (34) (b) 2. c., 3.39 (34) (b) 2. d.; to renumber and amend s. Ins 3.39 (7) (e); to amend ss. Ins 3.39 (2) (a) (intro), 3.39 (3) (cm), 3.39 (4) (intro), 3.39 (34) (b) 2., 3.39 (34) (b) 5. a., 3.39 (34) (b) 6, 3.39 (34) (c) 1., 3.39 Appendix 1; to repeal and recreate ss. Ins 3.39 (7) (d), 3.39 (13), 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 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.

Analysis: These changes bring the Wisconsin regulations in compliance with changes in federal law under H.R. 5661, 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 and Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"). 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, the suspension of benefits and premiums and the Medicare + Choice areas of federal preemption. 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 repeal of the sections regulating the sale of Medicare + Choice plans due to federal preemption.

Section 1: Section Ins 3.39 (2) (a) (intro.) is 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 policy as defined in s. 600.03 (28p) (a) and (c), Stats., including:

Section 2: 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 3: Section Ins 3.39 (4) (intro.) is amended to read:

Ins 3.39 (4) MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY AND CERTIFICATE REQUIREMENTS. 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 or marketed as a Medicare supplement or as a Medicare replacement policy, as defined in s. 600.03 (28p) (a) and (c), Stats., unless:

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

Ins 3.39 (4) (a) 18p. Each Medicare supplement policy shall provide, and contain within the policy, 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 5: Section Ins 3.39 (7) (b) and (7) (c) are repealed.

Section 6: Section Ins 3.39 (7) (d) is repealed and recreated to read:

Ins 3.39 (7) (b) Medicare replacement 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 the following:

1. Medicare replacement 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 policy shall include a written provision providing for the right to disenroll which shall:

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 similar language approved by the commissioner: You may 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 your disenrollment becomes effective. The plan will return any unused premium to you on a pro rata basis.

2. The Medicare replacement 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.

Section 7: **Section Ins 3.39 (7) (e) is renumbered 3.39 (7) (c) and amended to read:**

Ins 3.39 (7) (c) Each ~~Medicare + Choice issuer in order to state that it meets the minimum standards for Medicare + Choice policies set by this rule and each~~ Medicare Cost issuer , as defined in s. 600.03 (28p) (a) and (c), Stats., shall offer the rider as described in sub. (5) (i) 2. and may offer the other riders described in sub. (5) (i) and other coverages as authorized by the health care financing administration.

Section 8. Section Ins 3.39 (7) (f) is renumbered 3.39 (7) (d).

Section 9. Section Ins 3.39 (7) (g) is repealed.

Section 10: **Section Ins 3.39 (13) is repealed and recreated to read:**

Ins 3.39 (13) EXEMPTION OF CERTAIN POLICIES AND CERTIFICATES FROM CERTAIN STATUTORY MEDICARE SUPPLEMENT REQUIREMENTS. 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 policies as defined in s. 600.03 (28p) (a) and (c), Stats., shall not be subject to either of the following:

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

(b) The special pre-existing diseases provisions for Medicare supplement policies set forth in s. 632.76 (2) (b), Stats.

Section 11: Section Ins 3.39 (21) (f) is repealed.

Section 12: 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 in subpars. a. to f. that would permit discontinuance of the individual's enrollment and such provider if such individual were enrolled in a Medicare + Choice plan:

Section 13: 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 C of Medicare has been terminated, or the organization or plan has notified the individual of an impending termination of the certification.

Section 14: Section Ins 3.39 (34) (b) 2. b. is renumbered 3.39 (34) (b) 2. c.

Section 15: 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 the plan.

Section 16: Section Ins 3.39 (34) (b) 2. c. is renumbered 3.39 (34) (b) 2. d.

Section 17: Section Ins 3.39 (34) (b) 2. d. is renumbered 3.39 (34) (b) 2. e.

Section 18: Section Ins 3.39 (34) (b) 2. f. is created to read:

Ins 3.39 (34) (b) 2. f. i. An individual described in par. (b) 2. may elect to apply par. (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 par. (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 par. (a) shall only become effective upon termination of coverage under the Medicare + Choice plan involved.

Section 19: 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 20: 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 21: 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 subd. (5) (i) 7.

Section 22: 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 described in sub. (5) along with any riders available or a Medicare Select policy as defined in sub. (30).

Section 23: Section Ins 3.39 appendix 1 is amended to read:

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

or

OUTLINE OF MEDICARE REPLACEMENT INSURANCE

(The designation and caption required by subd. (4) (b) 4.)

PREMIUM INFORMATION

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

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 right s 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.

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

replacement for ~~medicare~~ 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.

(3) (a) In 24-point type: For ~~medicare~~ Medicare supplement policies marketed by intermediaries:

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

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

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

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

(insert company's name) has contracted with ~~medicare~~ Medicare to provide ~~medicare~~ 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~~ Medicare services, must be provided or authorized by (insert company's name).

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

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

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

MEDICARE PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

Note: Issuers should include only the wording which 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: ~~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.]

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $1500 DEDUCTIBLE] PLAN PAYS	YOU PAY
Hospitalization* Semiprivate room and board, General nursing and miscellaneous hospital services and supplies. Includes meals, special care units, recovery room, anesthesia and rehabilitation services.	First 60 days	All but $ (current deductible)	$0 or ☐ OPTIONAL PART A DEDUCTIBLE RIDER	
	61st to 90th days	All but $ (current amount per day)	$ (current amount per day)	
	91st to 150th days	All but $ (current amount per day)	$ (current amount per day)	
	Beyond 150 days	Nothing	All	
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	100% of costs	$0	
	Additional 80 days	All but $ (current amount per day)	$ (current amount per day)	
Inpatient Psychiatric care in a Participating psychiatric Hospital		190 days per lifetime	175 additional days per lifetime	
Blood		All but 1st 3 pints	First 3 pints	
Home health care		100% of charges for visits considered medically necessary by Medicare	40 visits or ☐ OPTIONAL ADDITIONAL HOME HEALTH RIDER	

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

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 24: These changes first applies to policies issued on or after January 1, 2001, or the effective date of this rule, whichever is later.

Section 25: 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 21 day of June 2001.

Connie L. O'Connell

Connie L. O'Connell
Commissioner of Insurance

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott McCallum, Governor
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June 19, 2001

REPORT ON Section Ins 3.39, Wis. Adm. Code, relating to Medicare Supplement and Replacement Plans

Clearinghouse Rule No 00-133
Submitted Under s. 227.19 (3), Stats.
The proposed rule-making order is attached.

(a) Statement of need for the proposed rule

Significant changes have been made in federal legislation and the national association of insurance commissioners (""NAIC") model regulation. The proposed changes bring the Wisconsin regulations in compliance with both the federal law and NAIC model rule.

(b) Modifications made in proposed rule based on testimony at public hearing:

The proposed rule has been significantly modified due to changes in federal legislation that in turn also addressed several of the comments received by the Office.

(c) Persons who appeared or registered regarding the proposed rule:

Appearances For:
Michelle Webb, Blue Cross & Blue Shield United of Wisconsin
Donna Bryant, Wisconsin Board on Aging and Long-term Care

Appearances Against:
None

Appearances For Information:
None

Registrations For:
William Donaldson, Wisconsin Board on Aging and Long-term Care

Registrations Against:
None

Registrations Neither for nor against:
None

Letters received:
Blue Cross & Blue Shield United of Wisconsin
Wisconsin Board on Aging and Long-term Care
United Healthcare of Wisconsin, Inc.

(d) Response to Legislative Council staff recommendations

All comments were complied with and corrected except the following:

The proposed rule is based upon a NAIC model regulation and it is not possible to avoid subdivisions of sections beyond what is permissible in according to the Manual. Additionally, for consistency of terminology and references among states implementing the NAIC model regulation, there are references to the Social Security Act rather than specific U.S. Code.

(e) Regulatory flexibility analysis

1. No issues were raised by small businesses during the hearing on the proposed rule.
2. The proposed rule does not impose any additional reporting requirements on small businesses.
3. The proposed rule does not require any additional measures or investments by small businesses.
4. No methods specified under s. 227.114 (2), Stats., are included in the proposed rule.

(f) Fiscal Effect

See fiscal estimate attached to proposed rule.

Enclosure: Legislative Council Staff Recommendations
INS 339 Rule Legislative Report 1.Doc

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HONORABLE JUDITH ROBSON
SENATE CO-CHAIRPERSON
JOINT COMM FOR REVIEW OF ADM RULES
SOUTH STATE CAPITOL RM 15
MADISON WI 53702

Re: Section Ins 3.39, Wis. Adm. Code, relating to Medicare Supplement and Replacement Plans

Clearinghouse Rule No. 00-133

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Sincerely,

Connie L. O'Connell

Connie L. O'Connell
Commissioner

CLO:JW
Attachment: 1 copy rule & legislative report

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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.

Analysis: These changes bring the Wisconsin regulations in compliance with changes in federal law under H.R. 5661, 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 and Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"). 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, the suspension of benefits and premiums and the Medicare + Choice areas of federal preemption. 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 repeal of the sections regulating the sale of Medicare + Choice plans due to federal preemption.

Section 1: Section Ins 3.39 (2) (a) (intro.) is 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 policy as defined in s. 600.03 (28p) (a) and (c), Stats., including:

Section 2: 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 3: Section Ins 3.39 (4) (intro.) is amended to read:

Ins 3.39 (4) MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY AND CERTIFICATE REQUIREMENTS. 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 or marketed as a Medicare supplement or as a Medicare replacement policy, as defined in s. 600.03 (28p) (a) and (c), Stats., unless:

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

Ins 3.39 (4) (a) 18p. Each Medicare supplement policy shall provide, and contain within the policy, 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 5: Section Ins 3.39 (7) (b) and (7) (c) are repealed.

Section 6: Section Ins 3.39 (7) (d) is repealed and recreated to read:

Ins 3.39 (7) (b) Medicare replacement 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 the following:

1. Medicare replacement 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 policy shall include a written provision providing for the right to disenroll which shall:

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 similar language approved by the commissioner: You may 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 your disenrollment becomes effective. The plan will return any unused premium to you on a pro rata basis.

2. The Medicare replacement 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.

Section 7: Section Ins 3.39 (7) (e) is renumbered 3.39 (7) (c) and amended to read:

Ins 3.39 (7) (c) Each ~~Medicare + Choice issuer in order to state that it meets the minimum standards for Medicare + Choice policies set by this rule and each~~ Medicare Cost issuer , as defined in s. 600.03 (28p) (a) and (c), Stats., shall offer the rider as described in sub. (5) (i) 2. and may offer the other riders described in sub. (5) (i) and other coverages as authorized by the health care financing administration.

Section 8. Section Ins 3.39 (7) (f) is renumbered 3.39 (7) (d).

Section 9. Section Ins 3.39 (7) (g) is repealed.

Section 10: Section Ins 3.39 (13) is repealed and recreated to read:

Ins 3.39 (13) EXEMPTION OF CERTAIN POLICIES AND CERTIFICATES FROM CERTAIN STATUTORY MEDICARE SUPPLEMENT REQUIREMENTS. 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 policies as defined in s. 600.03 (28p) (a) and (c), Stats., shall not be subject to either of the following:

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

(b) The special pre-existing diseases provisions for Medicare supplement policies set forth in s. 632.76 (2) (b), Stats.

Section 11: Section Ins 3.39 (21) (f) is repealed.

Section 12: 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 in subpars. a. to f. that would permit discontinuance of the individual's enrollment and such provider if such individual were enrolled in a Medicare + Choice plan:

Section 13: 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 C of Medicare has been terminated, or the organization or plan has notified the individual of an impending termination of the certification.

Section 14: Section Ins 3.39 (34) (b) 2. b. is renumbered 3.39 (34) (b) 2. c.

Section 15: 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 the plan.

Section 16: Section Ins 3.39 (34) (b) 2. c. is renumbered 3.39 (34) (b) 2. d.

Section 17: Section Ins 3.39 (34) (b) 2. d. is renumbered 3.39 (34) (b) 2. e.

Section 18: Section Ins 3.39 (34) (b) 2. f. is created to read:

Ins 3.39 (34) (b) 2. f. i. An individual described in par. (b) 2. may elect to apply par. (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 par. (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 par. (a) shall only become effective upon termination of coverage under the Medicare + Choice plan involved.

Section 19: 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 20: 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 21: 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 subd. (5) (i) 7.

Section 22: 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 described in sub. (5) along with any riders available or a Medicare Select policy as defined in sub. (30).

Section 23: Section Ins 3.39 appendix 1 is amended to read:

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

or

OUTLINE OF MEDICARE REPLACEMENT INSURANCE

(The designation and caption required by subd. (4) (b) 4.)

PREMIUM INFORMATION

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

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 right s 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.

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

replacement for ~~medicare~~ 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.

(3) (a) In 24-point type: For ~~medicare~~ Medicare supplement policies marketed by intermediaries:

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

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

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

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

(insert company's name) has contracted with ~~medicare~~ Medicare to provide ~~medicare~~ 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~~ Medicare services, must be provided or authorized by (insert company's name).

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

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

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

MEDICARE PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

Note: Issuers should include only the wording which 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: ~~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.]

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $1500 DEDUCTIBLE] PLAN PAYS	YOU PAY
Hospitalization* Semiprivate room and board, General nursing and miscellaneous hospital services and supplies. Includes meals, special care units, recovery room, anesthesia and rehabilitation services.	First 60 days	All but $ (current deductible)	$0 or ☐ OPTIONAL PART A DEDUCTIBLE RIDER	
	61st to 90th days	All but $ (current amount per day)	$ (current amount per day)	
	91st to 150th days	All but $ (current amount per day)	$ (current amount per day)	
	Beyond 150 days	Nothing	All	
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	100% of costs	$0	
	Additional 80 days	All but $ (current amount per day)	$ (current amount per day)	
Inpatient Psychiatric care in a Participating psychiatric Hospital		190 days per lifetime	175 additional days per lifetime	
Blood		All but 1st 3 pints	First 3 pints	
Home health care		100% of charges for visits considered medically necessary by Medicare	40 visits or ☐ OPTIONAL ADDITIONAL HOME HEALTH RIDER	

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

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 24: These changes first applies to policies issued on or after January 1, 2001, or the effective date of this rule, whichever is later.

Section 25: 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 21 day of June 2001.

Connie L. O'Connell

Connie L. O'Connell
Commissioner of Insurance

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott McCallum, Governor
Connie L. O'Connell, Commissioner

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June 19, 2001

REPORT ON Section Ins 3.39, Wis. Adm. Code,
relating to Medicare Supplement and Replacement
Plans

Clearinghouse Rule No 00-133
Submitted Under s. 227.19 (3), Stats.
The proposed rule-making order is attached.

(a) Statement of need for the proposed rule

Significant changes have been made in federal legislation and the national association of insurance commissioners (""NAIC") model regulation. The proposed changes bring the Wisconsin regulations in compliance with both the federal law and NAIC model rule.

(b) Modifications made in proposed rule based on testimony at public hearing:

The proposed rule has been significantly modified due to changes in federal legislation that in turn also addressed several of the comments received by the Office.

(c) Persons who appeared or registered regarding the proposed rule:

Appearances For:
Michelle Webb, Blue Cross & Blue Shield United of Wisconsin
Donna Bryant, Wisconsin Board on Aging and Long-term Care

Appearances Against:
None

Appearances For Information:
None

Registrations For:
William Donaldson, Wisconsin Board on Aging and Long-term Care

Registrations Against:
None

Registrations Neither for nor against:
None

Letters received:
Blue Cross & Blue Shield United of Wisconsin
Wisconsin Board on Aging and Long-term Care
United Healthcare of Wisconsin, Inc.

(d) Response to Legislative Council staff recommendations

All comments were complied with and corrected except the following:

The proposed rule is based upon a NAIC model regulation and it is not possible to avoid subdivisions of sections beyond what is permissible in according to the Manual. Additionally, for consistency of terminology and references among states implementing the NAIC model regulation, there are references to the Social Security Act rather than specific U.S. Code.

(e) Regulatory flexibility analysis

1. No issues were raised by small businesses during the hearing on the proposed rule.
2. The proposed rule does not impose any additional reporting requirements on small businesses.
3. The proposed rule does not require any additional measures or investments by small businesses.
4. No methods specified under s. 227.114 (2), Stats., are included in the proposed rule.

(f) Fiscal Effect

See fiscal estimate attached to proposed rule.

Enclosure: Legislative Council Staff Recommendations
INS 339 Rule Legislative Report 1.Doc