Chapter Ins 3

CASUALTY INSURANCE

Ins 3.01 Accumulation benefit riders attached to health and accident policies. Except where such rider is used only on a policy replacing the company's own policy, and so recites, no rider providing for accumulations of benefits will be approved for use upon any policy of health and accident insurance, whether it is proposed to issue such rider with or without an additional premium. Such rider operates as an aid to twisting the policies of another company in such manner as to make its use a direct encouragement of this practice.

Ins 3.02 Automobile fleets, vehicles not included in. Individually owned motor vehicles cannot be included or covered by fleet rates. The determining factor for inclusion under fleet coverage must be ownership and not management or use.

Ins 3.04 Dividends not deducted from premiums in computing loss reserves. Premiums returned to policyholders as dividends may

not be deducted from the earned premiums in computing loss reserves under s. 623.04, Stats.

History: 1-2-56; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.09 Mortgage guaranty insurance. (1) PURPOSE. This rule implements and interprets, including but not limited to, s. Ins 6.75 (2) (i) and ss. 611.02, 611.24, 618.01, 618.21, 620.02 and 623.04, Stats., for the purpose of establishing minimum requirements for the transaction of mortgage guaranty insurance.

(2) SCOPE. This rule shall apply to the underwriting, investment, marketing, rating, accounting and reserving activities of insurers which write the type of insurance authorized by s. Ins 6.75 (2) (i).

(3) DEFINITIONS. (a) Mortgage guaranty insurance is that kind of insurance authorized by s. Ins 6.75 (2) (i), and includes the guarantee of the payment of rentals under leases of real estate in which the lease extends for 3 years or longer.

(b) As used in this rule, "person" means any individual, corporation, association, partnership or any other legal entity.

(4) DISCRIMINATION. No mortgage guaranty insurer may discriminate in the issuance or extension of mortgage guaranty insurance on the basis of the applicant's sex, marital status, race, color, creed or national origin.

(5) LIMITATION OF TOTAL LIABILITY ASSUMED. A mortgage guaranty insurer shall not at any time have outstanding a total liability under its aggregate insurance policies, computed on the basis of its election to limit coverage and net of reinsurance assumed and of reinsurance ceded to an insurer authorized to transact such reinsurance in this state, exceeding 25 times the sum of its contingency reserve established under sub. (14) and its surplus as regards policyholders.

(6) LIMITATION ON INVESTMENT. A mortgage guaranty insurer shall not invest in notes or other evidences of indebtedness secured by mortgage or other lien upon real property. This section shall not apply to obligations secured by real property, or contracts for the sale of real property, which obligations or contracts of sale are acquired in the course of the good faith settlement of claims under policies of insurance issued by the mortgage guaranty insurer, or in the good faith disposition of real property so acquired.

(7) LIMITATION ON ASSUMPTION OF RISKS. A mortgage guaranty insurer shall not insure loans secured by properties in a single or contiguous housing or commercial tract in excess of 10% of the insurer's admitted assets. A mortgage guaranty insurer shall not insure a loan secured by a single risk in excess of 10% of the insurer's admitted assets. In determining the amount of such risk or risks, the insurer's liability shall be computed on the basis of its election to limit coverage and net of reinsurance ceded to an insurer authorized to transact such reinsurance in this state. "Contiguous" for the purpose of this subsection means not separated by more than one-half mile.

(8) REINSURANCE. A mortgage guaranty insurer may, by contract, reinsure any insurance it transacts in any assuming insurer authorized to transact mortgage guaranty insurance in this state, except it shall not

enter into reinsurance arrangements designed to circumvent the compensation control provisions of sub. (15) or the contingency, reserve requirement of sub. (14). It is the intent of this rule that the unearned premium reserve required by sub. (13) and the contingency reserve required by sub. (14) shall be established and maintained in appropriate proportions in relation to risk retained by the original insurer and by the assuming reinsurer so that the total reserves established shall not be less than the reserve required by subs. (13) and (14).

(9) ADVERTISING. No mortgage guaranty insurer or any agent or representative of a mortgage guaranty insurer shall prepare or distribute or assist in preparing or distributing any brochure, pamphlet, report or any form of advertising to the effect that the real estate investments of any financial institution are "insured investments", unless the brochure, pamphlet, report or advertising clearly states that the loans are insured by insurers possessing a certificate of authority to transact mortgage guaranty insurance in this state or are insured by an agency of the federal government, as the case may be.

(10) POLICY FORMS. All policy forms and endorsements shall be filed with and be subject to approval of the commissioner. With respect to owner-occupied, single-family dwellings, the mortgage guaranty insurance policy shall provide that the borrower shall not be liable to the insurance company for any deficiency arising from a foreclosure sale.

(11) PREMIUM. (a) The total consideration charged for mortgage guaranty insurance policies, including policy and other fees or similar charges, shall be considered premium and must be stated in the policy and shall be subject to the reserve requirements of subs. (13) and (14).

(b) The rate making formula for mortgage guaranty insurance shall contain a factor or loading sufficient to produce the amount required for the contingency reserve prescribed by sub. (14).

(12) REPORTING. (a) The financial condition and operations of a mortgage guaranty insurer shall be reported annually on the fire and casualty annual statement form specified by s. Ins 7.01 (5) (a), Wis. Adm. Code.

(b) The total contingency reserve required by sub. (14) shall be reported on line 1, page 3 or on line 22, page 3 of the annual statement. If the contingency reserve is reported on line 1, page 3, appropriate entries must be made on Exhibit 3-A, page 9 of the annual statement. The change in contingency reserve for the year shall be reported on line 5, page 4 of the annual statement as a deduction from underwriting income. The development of the contingency reserve shall be shown in Schedule K of the annual statement as follows:

1. Net premiums earned on policies during the 120 months prior to the annual statement date shall be shown on line 3 (a) of Schedule K;

2. Incurred losses in excess of 35% of earned premiums of any calendar year included in line 3 (a) shall be reported in line 3 (c) of Schedule K; and

3. Appropriate entries shall be made in lines 3 (b), 3 (d), 3 (e), 3 (f), (4) and (5) of Schedule K.

(c) A mortgage guaranty insurer shall compute and maintain adequate case basis and other loss reserves to be reported in Underwriting and Investment Exhibit Part 3-A—Unpaid Losses and Loss Adjustment Expenses, page 9 of the annual statement form. The method used to determine the loss reserve shall accurately reflect loss frequency and loss severity and shall include components for claims reported and unpaid, and for claims incurred but not reported, including estimated losses on:

1. Insured loans which have resulted in the conveyance of property which remains unsold;

2. Insured loans in the process of forclosure;

3. Insured loans in default for 4 months or for any lesser period which is defined as default for such purposes in the policy provisions; and

4. Insured leases in default for 4 months or for any lesser period which is defined as default for such purposes in the policy provisions.

(d) Expenses shall be recorded and reported in accordance with ss. Ins 6.30 and 6.31, Wis. Adm. Code.

(e) Amounts released from the contingency reserve pursuant to sub. (14) shall be treated on a first-in-first-out basis.

(13) UNEARNED PREMIUM RESERVE. (a) A mortgage guaranty insurer shall compute and maintain an unearned premium reserve on an annual or on a monthly pro rata basis on all unexpired coverage, except that in the case of premiums paid in advance for any coverage issued with a term shown in the schedule below the annual unearned premium factor specified shall apply:

Unearned Premium Factor to be Applied to Premiums in Force on Valuation Date

Contract Year Current at Valuation Date	4 Year Coverage Period	5 Year Coverage Period	6 Year Coverage Period	7 Year Coverage Period	8 Year Coverage Period	9 Year Coverage Period
1	95.7%	96.5%	97.0%	97.3%	97.5%	97.7%
2	76.4%	81.0%	83.7%	85.4%	86.5%	87.3%
3	45.2%	56.0%	62.2%	66.2%	68.8%	70.4%
4	14.5%	31.3%	41.1%	47.4%	51.3%	53.8%
5		9.8%	22.7%	31.0%	36.2%	39.4%
6			7.1%	17.1%	23.3%	27.2%
7				5.4%	12.5%	16.9%
8					3.8%	8.6%
9						2.5%
10						
11						
12						
13						
14						
15						

Contract Year Current at Valuation Date	10 Year Coverage Period	11 Year Coverage Period	12 Year Coverage Period	13 Year Coverage Period	14 Year Coverage Period	15 Year Coverage Period
1	97.7%	97.8%	97.8%	97.8%	97.8%	97.8%
2	87.6%	87.9%	88.1%	88.1%	88.2%	88.2%
3	71.3%	71.9%	72.3%	72.5%	72.6%	72.6%
4	55.3%	56.1%	56.7%	57.1%	57.2%	57.3%
5	41.3%	42.5%	43.2%	43.7%	43.9%	44.0%
6	29.5%	30.9%	31.8%	32.3%	32.7%	32.8%
7	19.6%	21.2%	22.1%	22.8%	23.2%	23.3%
8	11.6%	13.3%	14.4%	15.1%	15.5%	15.7%
9	5.6%	7.5%	8.6%	9.3%	9.9%	10.1%
10	1.6%	3.4%	4.6%	5.4%	6.0%	6.2%
11		0.9%	2.1%	2.9%	3.5%	3.7%
12			0.6%	1.3%	1.9%	2.1%
13				0.4%	0.9%	1.1%
14					0.3%	0.5%
15						0.1%

These unearned premium factors are calculated on the assumption that on the average a contract is written in the middle of the calendar year and that these factors are applied annually to groups of contracts segregated by term and expiration year. These factors include one-half of the earned premium applicable to the contract year current at the valuation date.

(b) On an annual premium plan that portion of the first year premium, excluding policy and other fees or similar charges, which exceeds twice the subsequent renewal premium rate, shall be considered a deferred risk charge and amortized in accordance with factors specified for a 10 year term coverage in paragraph (a) or in accordance with factors specified for a lesser term coverage in paragraph (a) as approved by the commissioner.

(c) On premiums paid in advance for coverage periods in excess of 15 years, the unearned portion of the premium during the first 15 years of coverage shall be the premium collected minus an amount equal to the premium that would have been earned had the applicable premium for 15 years' coverage been received. The premium remaining after 15 years shall be released from the unearned premium reserve pro rata over the remaining term of coverage.

(14) CONTINGENCY RESERVE. (a) A contingency loss reserve shall be established and maintained for the purpose of protecting insureds against the effect of adverse economic cycles and to permit mortgage guaranty insurers to comply with section 832 (e) of the Internal Revenue Code of 1954, as amended.

(b) Subject to subsection (8) relating to reinsurance there shall be an annual contribution to the contingency reserve which in the aggregate shall be the greater of:

1. 50% of the earned premium reported on line 1, page 4 of the fire and casualty annual statement; or

2. The sum of:

a. $1.25 per $1,000 of face amount of mortgage guaranty insurance in force at year end on residential buildings designed for occupany by not more than four families with coverage not exceeding 25% of the entire indebtedness; and

b. $1.875 per $1,000 of face amount of mortgage guaranty insurance in force at year end on residential buildings designed for occupancy by five

r more families with coverage not exceeding 20% of the indebtedness; nd

c. $2.50 per $1,000 of face amount of mortgage guaranty insurance in orce at year end on buildings occupied for industrial or commercial pur- oses with coverage not exceeding 20% of the entire indebtedness.

(c) If the coverage of residential mortgages on buildings designed for ccupancy by not more than 4 families exceeds 25%, or if the coverage n residential mortgages on buildings designed for occupancy by 5 or nore families exceeds 20% or if the mortgage guaranty coverage is not xpressly provided for in this rule, the commissioner shall establish a ate formula factor that will produce a contingency reserve adequate for he risk assumed. The face amount of an insured mortgage shall be com- uted before any reduction by the insurer's election to limit its coverage o a portion of the entire indebtedness.

(d) The contingency reserve established by this subsection shall be naintained for 120 months. That portion of the contingency reserve es- ablished and maintained for more than 120 months shall be released nd shall no longer constitute part of the contingency reserve.

(e) Subject to the approval of the commissioner, the contingency re- erve shall be available to the extent necessary to make loss payments ither when the incurred losses in a year exceed 35% of the earned pre- nium in that year or when incurred losses in a year exceed 70% of the mount contributed to the contingency reserve, whichever is greater. unds used in this manner shall be accounted for on a first-in-first-out asis as provided in subsection (12) (e).

(15) CHARGES, COMMISSIONS AND REBATES. (a) Every mortgage guar- nty insurer shall adopt, print and make available a schedule of pre- nium charges for mortgage guaranty insurance coverages. The schedule hall show the entire amount of premium charge for each type of mort- age guaranty insurance coverage issued by the insurer.

(b) A mortgage guaranty insurer shall not knowingly pay, either di- ectly or indirectly to an owner, purchaser, mortgagee of the real prop- rty or any interest therein or to any person who is acting as agent, epresentative, attorney or employe of such owner, purchaser, or mort- agee any commission, remuneration, dividend or any part of its pre- nium charges or any other consideration as an inducement for or as ompensation on any mortgage guaranty insurance business.

(c) In connection with the placement of any insurance, a mortgage uaranty insurer shall not cause or permit any commission, fee, remu- eration, or other compensation to be paid to, or received by: any in- ured lender; any subsidiary or affiliate of any insured; any officer, di- ector or employe of any insured; any member of their immediate family; ny corporation, partnership, trust, trade association in which any in- ured is a member, or other entity in which any insured or any such fficer, director, or employe or any member of their immediate family as a financial interest; or any designee, trustee, nominee, or other agent r representative of any of the foregoing.

(d) A mortgage guaranty insurer shall not make any rebate of any ortion of the premium charge shown by the schedule required by para- raph (a). A mortgage guaranty insurer shall not quote any premium harge to any person which is different than that currently available to

others for the same type of mortgage guaranty insurancy coverage sold by the mortgage guaranty insurer. The amount by which any premium charge is less than that called for by the current schedule of premium charge is a rebate.

(e) A mortgage guaranty insurer shall not use compensating balances, special deposit accounts or engage in any practice which unduly delays its receipt of monies due or which involves the use of its financial resources for the benefit of any owner, mortgagee of the real property or any interest therein or any person who is acting as agent, representative, attorney or employe of such owner, purchaser or mortgagee as a means of circumventing any part of this rule. Except for commercial checking accounts and normal deposits in support of an active bank line of credit, any deposit account bearing interest at rates less than is currently being paid other depositors on similar deposits or any deposit in excess of amounts insured by an agency of the federal government shall be presumed to be an account in violation of this paragraph.

(f) A mortgage guaranty insurer shall make provision for prompt refund of any unearned premium in the event of termination of the insurance prior to its scheduled termination date. If the borrower paid or was charged for the premium, the refund shall be made to the borrower, or to the insured for the borrower's benefit, otherwise refund may be paid to the insured.

(g) This subsection is not intended to prohibit payment of appropriate policy dividends to borrowers.

(16) TRANSITION. Unearned premium reserves and contingency loss reserves shall be computed and maintained on risks insured after the effective date of this rule as required by subsections (13) and (14). Unearned premium reserves and contingency loss reserves on risks insured before the effective date of this rule may be computed and maintained either as required by subsection (13) and (14) or as required by Wis. Adm. Code section Ins 3.09 which was previously in effect and which was repealed on the effective date of this rule.

(17) CONFLICT OF INTEREST. (a) If a member of a holding company system as defined in Wis. Adm. Code section Ins 12.01 (3) (e), a mortgage guaranty insurer licensed to transact insurance in this state shall not, as a condition of its certificate of authority, knowingly underwrite mortgage guaranty insurance on mortgages originated by the holding company system or an affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate.

(b) A mortgage guaranty insurer, the holding company system of which it is a part or any affiliate shall not as a condition of the mortgage guaranty insurer's certificate of authority, pay any commissions, renumeration, rebates or engage in activities proscribed in subsection (15).

(18) LAWS OR REGULATIONS OF OTHER JURISDICTIONS. Whenever the laws or regulations of another jurisdiction in which a mortgage guaranty insurer subject to the requirements of this rule is licensed, require a larger unearned premium reserve or a larger contingency reserve in the

aggregate than that set forth in this rule, the establishment and maintenance of the larger unearned premium reserve or contingency reserve shall be deemed to be compliance with this rule.

History: Cr. Register, March, 1957, No. 15, eff. 4-1-57; am. (2), (3), (4) and (5), Register, January, 1959, No. 37, eff. 2-1-59; am. (4) (c), Register, August, 1959, No. 44, eff. 9-1-59; cr. (4) (e), Register, January, 1961, No. 61, eff. 2-1-61; am. (2), Register, January, 1967, No. 133, eff. 2-1-67; am. (2), (3) (a) and (b), and (4) (a) and (b); r. and recr. (5), Register, December, 1970, No. 180, eff. 1-1-71. r. and recr. Register, March, 1975, No. 231, eff. 4-1-75; emerg. am. (1), (2) and (3) (a), eff. 6-22-76; am. (1), (2) and (3) (a), Register, September, 1976, No. 249, eff. 10-1-76; am. (1), (2) and (3) (a), Register, March, 1979, No. 279, eff. 4-1-79.

Ins 3.11 Multiple peril insurance contracts. (1) PURPOSE AND SCOPE. (a) This rule implements and interprets section Ins 6.70 and chs. 625 and 631, Stats., by enumerating the minimum requirements for the writing of multiple peril insurance contracts. Nothing herein contained is intended to prohibit insurers or groups of insurers from justifying rates or premiums in the manner provided for by the rating laws.

(b) This rule shall apply to multiple peril insurance contracts permitted by section Ins 6.70, and which include a type or types of coverage or a kind or kinds of insurance subject to ch. 625, Stats.

(c) Types of coverage or kinds of insurance which are not subject to ch. 625, Stats., or to the filing requirement provisions thereof, may not be included in multiple peril insurance contracts otherwise subject to said sections unless such entire multiple peril insurance contract is filed as being subject to this rule and said sections and the filing requirements thereof.

(2) DEFINITION. Multiple peril insurance contracts are contracts combining 2 or more types of coverage or kinds of insurance included in any one or more than one paragraph of section Ins 6.75. Such contracts may be on the divisible or single (indivisible) rate or premium basis.

(3) RATE MAKING. (a) When underwriting experience is not available to support a filing, the information set forth in s. 625.12, Stats., may be furnished as supporting information.

(b) Premiums or rates may be modified for demonstrated, measurable, or anticipated variation from normal of the loss or expense experience resulting from the combination or types of coverage or kinds of insurance or other factors of the multiple peril insurance contract. Multiple peril contracts may be filed or revised on the basis of sufficient underwriting experience developed by the contract or such experience may be used in support of such filing.

(c) In the event that more than one rating organization cooperates in a single (indivisible) rate or premium multiple peril insurance filing, one of such cooperating rating organizations shall be designated as the sponsoring organization for such filing by each of the other cooperating rating organizations and evidence of such designation included with the filing.

(4) STANDARD POLICY. The requirements of section Ins 6.76 shall apply to any multiple peril insurance contract which includes insurance against loss or damage by fire.

History: Cr. Register, July, 1958, No. 31, eff. 8-1-58; am. (3) (a), Register, November, 1960, No. 59, eff. 12-1-60; emerg. am. (1), (2), (3) (a) and (4), eff. 6-22-76; am. (1), (2), (3)

Ins 3.42 Plans of conversion coverage. Pursuant to s. 632.897 (4) (b), Stats., the following plans of conversion coverage are established.

(1) *Plan 1—Basic Coverage*—Plan 1 basic coverage consists of the following:

(a) Hospital room and board daily expense benefits in a maximum dollar amount approximating the average semi-private rate charged in the major metropolitan area of this state, for a maximum duration of 70 days per calendar year;

(b) Miscellaneous in-hospital expenses, including anesthesia services, up to a maximum amount of 20 times the hospital room and board daily expense benefits per calendar year; and

(c) In-hospital and out-of-hospital surgical expenses payable on a usual, customary and reasonable basis up to a maximum benefit of $2,000 a calendar year.

(2) *Plan 2—Major Medical Expense Coverage*—Plan 2 major medical expense coverage shall consist of benefits for hospital, surgical and medical expenses incurred either in or out of a hospital of the following:

(a) A lifetime maximum benefit of $75,000.

(b) Payment of benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits will be paid at 100% for the remainder of the benefit period; provided, however, benefits for out-patient mental illness, if covered by the policy, may be provided at a lesser rate, but not below 50%, and surgical expenses will be provided at a usual, customary and reasonable level.

(c) A deductible for each benefit period of $500 except that the deductible shall be $1,000 for each benefit period for a policy insuring members of a family. All covered expenses of any insured family member may be applied to satisfy the deductible.

(d) A "benefit period" shall be defined as a calendar year.

(e) Payment for all services covered under the contract by any licensed health care professional qualified to provide the services.

(3) *Plan 3—Major Medical Expense Coverage*—Plan 3 major medical expense coverage shall consist of benefits for hospital, surgical and medical expenses incurred either in or out of a hospital of the following:

(Same as Plan 2 except that maximum benefit is $100,000 and deductible is $1,000 for an individual and $2,000 for a family.)

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.43 High limit comprehensive plan of benefits. (1) A policy form providing a high limit comprehensive plan of benefits may be approved as an individual conversion policy as provided by s. 632.897 (4) (b), Stats., if it provides comprehensive coverage of expenses of hospital, surgical and medical services of not less than the following:

(a) A lifetime maximum benefit of $250,000.

(b) Payment of benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits will be paid at 100% for the remainder of the benefit period; provided, however, benefits for out-patient mental illness, if covered by the policy, may be provided at a lesser rate, but not below 50%, and surgical expenses will be provided at a usual, customary and reasonable level.

(c) A deductible for each benefit period of at least $250 and not more than $500 except that the deductible shall be at least $250 and not more than $1,000 for each benefit period for a policy insuring members of a family. All covered expenses of any insured family member may be applied to satisfy the deductible.

(d) A "benefit period" shall be defined as a calendar year.

(e) Payment for all services covered under the contract by any licensed health care professional qualified to provide the services.

(2) the filing procedures of s. Ins 3.12, Wis. Adm. Code, shall apply to policy forms filed as individual conversion policies.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.44 Effective date of s. 632.897, Stats. (1) Section 632.897, Stats., applies to group policies issued or renewed on or after May 14, 1980, or if a policy is not renewed within two years after the effective date of the act, s. 632.897, Stats., is effective at the end of 2 years from May 14, 1980.

(2) (a) A group policy as defined in s. 632.897 (1) (c) 1 or 3 shall be considered to have been renewed on any date specified in the policy as a renewal date or on any date on which the insurer or the insured changed the rate of premium for the group policy.

(b) A group policy as defined in s. 632.897 (1) (c) 2 shall be considered to have been renewed on any date on which an underlying collective bargaining agreement or other underlying contract is renewed, or on which a significant change is made in benefits.

(3) Section 632.897, Stats., applies to individual policies issued or renewed after May 14, 1980, except that it shall not apply to any individual policy in force on May 13, 1980, in which the insurer does not have the option of changing premiums.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.45 Conversion policies by insurers offering group policies only. Section 632.897 (4) (d) (first sentence), Stats., establishes that an insurer offering group policies only is not required to offer individual coverage. Since the insurer has no individual conversion policies which it may offer, it may not require a terminated insured who elected to continue coverage under s. 632.897 (2), Stats., to convert to individual coverage under s. 632.897 (6), Stats., after 12 months. The terminated person may continue group coverage except as provided in s. 632.897 (3) (a), Stats.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.46 Standards for nursing home insurance. (1) FINDINGS. Information on file in the office of the commissioner of insurance shows

that significant misunderstanding exists with respect to nursing home insurance. In many cases, coverage under these policies is much less than the use of the label would warrant and includes few meaningful benefits beyond those already available to consumers as a result of s. 632.78 (4), Stats., and Ins 3.39, and the commissioner of insurance finds that such policies are inequitable, misleading, deceptive, obscure, and encouraging of misrepresentation as considered by s. 631.20 (2), Stats. Some of the sales presentations used to sell nursing home insurance are misleading, confusing, and incomplete, and the commissioner of insurance finds that such presentations are misleading and deceptive, and restrain competition unreasonably under s. 628.34 (12), Stats., and their continued use would constitute an unfair trade practice under s. 628.34 (11), Stats.

(2) PURPOSE. (a) This section establishes minimum requirements for insurance which may be sold as nursing home insurance. A policy will be disapproved pursuant to s. 631.20, Stats., if that policy does not meet the minimum requirements specified in this section.

(b) This section seeks to reduce abuses and confusion associated with the sale of nursing home insurance by providing for minimum levels of coverage. It is designed not only to improve the ability of the consumer to make an informed choice as to whether to purchase a nursing home policy, but to assure that no policy will be approved by the commissioner as a "nursing home policy" unless it contains coverage which warrants the use of that label.

(3) SCOPE. (a) Except as provided in par. (b), this section applies to any individual insurance policy or rider which provides coverage primarily for confinement or care in a nursing home. This section applies regardless of restrictions on the level of nursing home care provided by a policy, i.e., skilled, intermediate, limited, personal or residential care.

(b) This section shall not apply to a rider designed specifically to meet the requirement for coverage of skilled nursing care set forth in s. 632.78 (4), Stats.

(c) This section applies to any individual insurance policy issued on or after July 1, 1982 to a person eligible for Medicare by reason of age which provides coverage for confinement or care in a nursing home in addition to providing hospital confinement indemnity coverage as defined in s. Ins 3.27 (4) (b) 6.

(4) DEFINITIONS. For the purpose of this section:

(a) "Medicare" means the hospital and medical insurance program established by title XVIII of the federal social security act of 1965, as amended.

(b) "Medicare eligible persons" means all persons who qualify for Medicare.

(c) "Nursing home" means a nursing home as defined by s. 50.01 (3), Stats.

(5) NURSING HOME POLICY REQUIREMENTS. No insurance policy covered by this section shall be structured, advertised, or marketed as a nursing home policy unless:

(a) The policy provides at a minimum the coverage set out in sub. (6) of this section and applicable statutes.

(b) The policy is plainly printed as to text in black or blue ink in a type of a style in general use, the size of which is uniform and not less than 10 point with a lower case unspaced alphabet length not less than 120 point.

(c) If the policy is sold to Medicare-eligible persons, it meets the requirements of s. Ins 3.39 (7) (b).

(6) MINIMUM COVERAGES. (a) Except as provided in pars. (b) through (g) of this section, a nursing home policy shall provide coverage for each person insured under the policy for any care received while a resident of any nursing home licensed by the state of Wisconsin pursuant to s. 50.02, Stats.

(b) Nursing home policies may limit benefits to a fixed daily benefit. The daily benefit may differ for different levels of care, but the lowest level of daily benefits shall not be less than $10 a day.

(c) Nursing home policies may provide benefits subject to a deductible, but the deductible amount shall not exceed 60 days per lifetime.

(d) Nursing home policies may provide benefits subject to a lifetime maximum, but the lifetime maximum shall be at least 365 days of coverage.

(e) Nursing home policies may limit coverage to care certified as necessary by the attending physician and periodically recertified as necessary.

(f) Nursing home policies are not required to duplicate payments by Medicare for nursing home care.

(g) The following limitations and exclusions are prohibited in nursing home policies:

1. Coverge limited to only certain levels of care, such as skilled care.

2. Coverage limited to care received as a result of sickness or injury.

3. Coverage limited to care received after a hospital confinement.

(6m) SEVERABILITY. If any provision of this section or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this section which can be given effect without the invalid provision or application, and to this end the parts of this section are declared to be severable.

(7) EFFECTIVE DATE. This rule shall take effect November 1, 1981.

History: Cr. Register, June, 1981, No. 305, eff. 11-1-81; cr. (3) (c), Register, June, 1982, No. 318, eff. 7-1-82.

Ins 3.47 Cancer insurance solicitation. (1) FINDINGS. Information on file in the office of the commissioner of insurance shows that significant misunderstanding exists with respect to cancer insurance. Consumers are not aware of the limitations of cancer insurance and do not know how cancer insurance policies fit in with other health insurance coverage. Many of the sales presentations used in the selling of cancer insur-

ance are confusing, misleading and incomplete and consumers are not getting the information they need to make informed choices. The commissioner of insurance finds that such presentations and sales materials are misleading, deceptive and restrain competition unreasonably as considered by s. 628.34 (12), Stats., and that their continued use without additional information would constitute an unfair trade practice under s. 628.34 (11) and would result in misrepresentation as defined and prohibited in s. 628.34 (1), Stats.

(2) PURPOSE. The purpose of s. Ins 3.47 is to promulgate a rule interpreting s. 628.34 (12), relating to unfair trade practices. It requires insurers and intermediaries who sell cancer insurance to give all prospective buyers of cancer insurance a buyer's guide prepared by the National Association of Insurance Commissioners.

(3) SCOPE. This section applies to all individual, group and franchise insurance polices or riders which provide benefits for or are advertised as providing benefits primarily for the treatment of cancer. This rule does not apply to solicitations in which the booklet, "Health Insurance Advice for Senior Citizens," is given to applicants as required by s. Ins 3.39.

(4) DEFINITION. The "Information Sheet on Cancer Insurance" means the document which contains, and is limited to, the language set forth in Appendix I to this section.

(5) DISCLOSURE REQUIREMENTS. (a) The insurer and its intermediaries shall print and provide to all prospective purchasers of any policy subject to the rule a copy of the "Information Sheet on Cancer Insurance" at the time the prospect is contacted by an intermediary or insurer with an invitation to apply as defined in s. Ins 3.27 (5) (g).

(b) The "Information Sheet on Cancer Insurance" shall be printed in an easy to read type and not less than 12 pt. size.

(6) This rule shall become effective August 1, 1981.

History: Cr. Register, June, 1981, No. 306, eff. 8-1-81.

APPENDIX I

INFORMATION SHEET ON CANCER INSURANCE

Cancer Insurance is Not a Substitute for Comprehensive Coverage.

Should You Buy Cancer Insurance?

Caution: Limitations On Cancer Insurance.

Prepared by the National Association of Insurance Commissioners

CANCER INSURANCE . . .

Cancer insurance is one of the fastest growing and most controversial forms of health insurance. It provides benefits only if you get cancer. No policy will cover cancer diagnosed before you applied for the policy. Examples of other specified disease policies are heart attack or stroke policies. The information in this booklet applies to cancer insurance, but could very well apply to other specified disease policies.

CANCER INSURANCE IS NOT A SUBSTITUTE FOR COMPREHENSIVE COVERAGE . . .

Cancer treatment accounts for less than 6% of U.S. health expenses. In fact, no single disease accounts for more than a small proportion of the American public's health care bill. This is why it is essential to have insurance coverage for all conditions, not just cancer.

If you and your family are not protected against catastrophic medical costs, you should consider a major medical policy. These policies pay a large percentage of your covered costs after a deductible is paid either by you or your basic insurance. They often have very high maximums, such as $100,000 to $1,000,000. Major medical policies will cover you for any accident or sickness, including cancer. They cost more than cancer policies, but they are generally considered a better buy.

SHOULD YOU BUY CANCER INSURANCE? . . . MANY PEOPLE DON'T NEED IT

If you are considering cancer insurance, ask yourself three questions: Is my current coverage adequate for these costs? How much will the treatment cost if I do get cancer? How likely am I to contract the disease? If you have Medicare and want more insurance, a comprehensive Medicare supplement policy is what you need.

Low income people who are Medicaid recipients don't need any more insurance. If you think you might qualify, contact your local social service agency.

Duplicate Coverage is Expensive and Unnecessary. Buy basic coverage first. Make sure any cancer policy will meet needs not met by your basic insurance. You cannot assume that double coverage will result in double benefits. Many cancer policies advertise that they will pay benefits no matter what your other insurance pays. However, your basic policy may contain a Coordination of Benefits clause. That means it will not pay duplicate benefits. To find out if you can get benefits from both policies, check your regular insurance as well as the cancer policy.

Some Cancer Expenses May Not Be Covered Even by a Cancer Policy. Medical costs of cancer treatment vary. On the average, hospitalization accounts for 78% of such costs and physician services make up 13%. The remainder goes for other professional services, drugs and nursing home care. For 1978, the average hospital cost for cancer treatment was $4,228. Cancer patients often face large nonmedical expenses which are not usually covered by cancer insurance. Examples are home care, transportation and rehabilitation costs.

Don't be Misled by Emotions. While one in four Americans will get cancer over a lifetime, three in four will not. In any one year, only one American in 285 will get cancer. The odds are against a Policyholder receiving any benefits.

CAUTION: LIMITATIONS OF CANCER INSURANCE . . .

Cancer policies sold today vary widely in cost and coverage. Contact different companies and agents, and compare the policies before you buy. Here are some common limitations:

Some policies pay only for hospital care. Today cancer care treatment, including radiation, chemotherapy and some surgery, is often given on an outpatient basis. Because the average stay in the hospital for a cancer patient is only 16 days, a policy which pays only when you are hospitalized has limited value.

Many policies promise to increase benefits after a patient has been in the hospital for 90 consecutive days. However, 99% of all cancer patients spend less than 60 days in the hospital. Large dollar amounts for extended benefits have very little value for most patients.

Many cancer insurance policies have fixed dollar limits. For example, a policy might pay only up to $1,500 for surgery costs or $1,000 for radiation therapy, or it may have fixed payments such as $50 or $100 for each day in the hospital. Others limit total benefits to a fixed amount such as $5,000 or $10,000.

No policy will cover cancer diagnosed before you applied for the policy. Some policies will deny coverage if you are later found to have had cancer at the time of purchase, even if you did not know it.

Most cancer insurance does not cover cancer-related illnesses. Cancer or its treatment may lead to other physical problems, such as infection, diabetes or pneumonia.

Many policies contain time limits. Some policies require waiting periods of 30 days or even several months before you are covered. Others stop paying benefits after a fixed period of two or three years.

FOR ADDITIONAL HELP . . .

If you are considering a cancer policy, the company or agent should answer your questions. If you do not get the information you want, discuss the matter with your State Insurance Department.