CR 09-076

ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE AMENDING AND CREATING A RULE

To amend Ins 3.39 (5m) (e) (intro.) and 5., (6); (7) (a) (intro.), (8) (a) (intro.), (14m) (d) (intro.), (30m) (q); (34) (b) 1., (c) 1., and (ez) 1., and Appendix 3; and

To create Ins 3.39 (5m) (k), (7) (cm) and (dm), (30m) (p) 6., and (34) (b) 1s. and (f) 3., Wis. Adm. Code,

Relating to Medicare supplement and replacement guarantee issue eligibility.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. **Statutes interpreted:**

ss. 185.983 (1m), 600.03, 601.01 (2), 609.01 (1g) (b), 625.16, 628.34 (12), 628.38, 631.20 (2), 632.73 (2m), 632.76 (2) (b) and 632.81, 632.895 (6) and (9), Wis. Stats.

2. **Statutory authority:**

ss. 600.01 (2), 601.41 (3), 601.42, 628.34 (12), 628.38, 632.73, 632.76, 632.81, Wis. Stats.

3. **Explanation of OCI's authority to promulgate the proposed rule under these statutes:**

The statutes all relate to the commissioner's authority to promulgate rules regulating the business of insurance as it relates to Medicare supplement and Medicare replacement insurance products. Specifically, ss. 601.41, 625.16, 628.38, 632.73, 632.76, and 632.81, Wis. Stats., permit the commissioner to promulgate rules regulating various aspects of Medicare supplement and Medicare replacement products while s. 628.34, Wis. Stats., authorizes the commissioner to promulgate rules governing disclosure requirements and unfair marketing practices for disability policies, which includes Medicare supplement and Medicare replacement products.

4. **Related statutes or rules:**

The Centers for Medicare & Medicaid Services (CMS) required the National Association of Insurance Commissioners (NAIC) to make conforming changes to the Medigap model regulation and delegated the function of implementing the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Public Law 110-175) to NAIC. CMS delegates enforcement of MIPPA and the underlying Medicare supplement and Medicare replacement insurance products to the states that have incorporated the NAIC Model Act into the state's insurance regulations. To date Wisconsin has passed several NAIC Model Acts through statute including the most recent modification to the NAIC Medigap Model. In Wisconsin Medicare supplement and Medicare replacement products are currently regulated through s. Ins 3.39, Wis. Adm. Code, inclusive of the appendices. The proposed rule modifies and adds to s. Ins 3.39, Wis. Adm. Code in order to comply with the MIPPA and the NAIC requirements, to the extent necessary, and updates the appendices to reflect those changes.

5. The plain language analysis and summary of the proposed rule:

The proposed rule amends portions of the rule to more closely reflect the benefits provided by the NAIC Medicare Supplement Insurance Minimum Standards Model Act and reintroduces the use of high deductible Medicare supplement plans. Further, during prior rule-making the Board on Aging and Long-term Care requested broadening of the guarantee issue eligibility rights. The commissioner convened an advisory work group to assist in the review of existing guarantee issue rights and to determine whether revisions were warranted. The proposed rule includes two modifications to Ins. 3.39, Wis. Adm. Code, that arose from the recommendation of the advisory work group specific to guarantee issue rights.

Regarding modifications to the NAIC Model regulations relating to the two new federal plan designs intended to lower premiums by requiring insureds who pay either 50% of hospital inpatient charges or copayments for office and emergency room visits. The proposed rule limits availability combinations of riders that can be used with the newer benefits as certain combinations would make any premium savings illusory. Specifically, issuers cannot issue both the Medicare Part A Deductible Rider and the Medicare 50% Part A Deductible Rider to the same insured for the same period of coverage. Similarly, issuers cannot issue both the

Medicare Part B Deductible Rider and the Medicare Part B Copayments or Coinsurance Rider to the same insured for the same period of coverage.

The proposed rule further delineates that the Medicare Part B Copayment or Coinsurance Rider requires that the insured's copayment or coinsurance be the lesser of $20.00 per office visit or the Medicare Part B coinsurance amount, with emergency room visits covered at the lesser of $50.00 or the Medicare Part B coinsurance amount. The emergency room copayment or coinsurance amount shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

In addition to corrections, the proposed rule reintroduces the high-deductible Medicare supplement plan previously sunset. The reintroduction is in response to repeated requests from the industry and supported by the Board on Aging and Long-term Care. This permits insureds flexibility to purchase a product best suited to medical and financial needs. The product complies with the NAIC Model regulation is proposed to have policy effective on June 1, 2010 to permit issuers time to develop and have policy forms and advertising material approved by the office. The proposed rule also modified Appendix 3 to reflect these changes.

The annual high deductible shall be $2000.00 for 2010, and will be adjusted annually thereafter to reflect changes in the Consumer Price Index in the twelve-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00. The annual high deductible consists of out-of-pocket expenses, other than premiums, listed above and is in addition to any other specific benefit deductibles. An issuer must continue to make available for purchase any policy form or certificate form issued after May 31, 2010 that has been approved by the commissioner. A policy or certificate form will not be considered to be available for purchase unless the issuer actively offered it for sale within the previous twelve months. This is changed from an issue date of August 1, 1992.

Finally, the proposed rule also expands the category of eligible persons who are guaranteed issuance of Medicare supplements or Medicare replacement policies to those

whose payments for coverage substantially increase or to those whose plans terminate or cease to provide some or all such supplemental health benefits. The amount an individual pays for coverage under the plan is considered to substantially increase if the amount the individual pays for coverage under the plan increases by more than 25% from one 12-month period to the subsequent 12-month period, and the new payment for the employer-sponsored coverage is greater than the premium charged under the Medicare supplement plan for which the individual is applying. An issuer may require reasonable documentation to substantiate the increase of the cost of the coverage to the individual.

A second new guaranteed issue time period will arise when a hospital leaves a Medicare Select network. The issuer shall notify the insured that a hospital is leaving the Medicare Select network and that there is no other hospital within a 30-minute or 30-mile radius of the policyholder. This will trigger a guarantee issue opportunity for the insured affected by the change in network to purchase a new Medicare supplemental policy without being newly underwritten by the issuer.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

The proposed rule amendments will bring the rule in closer compliance with the NAIC Model Act. There are no existing or proposed federal regulations relating to the proposed changes in guarantee issue eligibility.

7. Comparison of similar rules in adjacent states as found by OCI:

Illinois: Illinois has adopted the NAIC Model regulation creating the new Medigap plans M and N, and to incorporate the hospice care benefit as well as the new and innovative benefit requirements as required by MIPPA. No other state has the guarantee issue provisions as revised or access requirements.

Iowa: Iowa makes available to its Medicare beneficiaries Medigap policies A through J as required by the Medicare reform provisions under OBRA 1990 and the prior NAIC Model

Regulation. Iowa has adopted the NAIC Model regulation as required. No other state has the guarantee issue provisions as revised or access requirements.

Michigan: Michigan makes available to its Medicare beneficiaries Medigap policies A through J as required by the Medicare reform provisions under OBRA 1990 and the prior NAIC Model Regulation. Michigan has not yet passed legislation to create new Medigap plans M and N, and to incorporate the hospice care benefit as well as the new and innovative benefit requirements as required by MIPPA. No other state has the guarantee issue provisions as revised or access requirements.

Minnesota: Minnesota, like Wisconsin, received a waiver from the federal standardization regulations. Minnesota makes available to its Medicare beneficiaries two standardized policies (basic and extended basic). Minnesota has adopted the GINA requirements of the NAIC Model regulation but as a waived state will not promulgate the MIPPA changes. No other state has the guarantee issue provisions as revised or access requirements.

8. A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:

CMS data indicate that Medicare currently covers 40 million Americans, 814,183 of whom are Wisconsin residents as of 2004. An estimated 27 percent of Medicare beneficiaries are covered by Medigap policies.

Information collected by the OCI indicates that 75 insurance companies offer Medicare supplement, Medicare cost and Medicare select (Medigap) policies to Wisconsin consumers eligible for Medicare due to age or disability. In addition, there are 25 insurance companies that have Medigap policyholders although the companies no longer market Medigap coverage in Wisconsin. At year end 2007, there were 247,142 Wisconsin Medicare beneficiaries with Medigap policies. The majority of these Wisconsin Medicare beneficiaries have Medigap policies that will be affected by the Medigap reforms under the MIPPA.

A 2000 report by CMS, Office of Research, Development, and Information, based on 2007 Medicare data indicates that Medicare paid 54-56% of the health care expenses of

persons 65 or over, and private health insurance, including Medicare supplement policies paid 16% of these health care expenses. The report indicated that overall annual medical expenses in 2005 per Medicare beneficiary equaled $6,697.

9. Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:

OCI reviewed financial statements and other reports filed by life, accident and health issuers and determined that none qualifies as a small business. Wisconsin currently has 75 insurance companies offering Medicare supplement, Medicare cost and Medicare select insurance plans. None of these issuers meets the definition of a small business under s. 227.114, Wis. Stats.

There may be limited effects on intermediaries, however the requirement will not be significant and will mainly be comprised of learning new products and options for seniors.

10. See the attached Private Sector Fiscal Analysis.

The proposed rule will not significantly impact the private sector. Issuers offering Medigap policies (Medicare supplement, Medicare cost, and Medicare select policies) will incur costs associated with developing new Medigap policies and marketing materials, mailing riders and explanatory materials to existing policyholders and reprogramming claim processing systems. However, these costs are offset by the issuers' ability to continue offering Medigap policies to Wisconsin consumers and will not be significant. Intermediaries will need to use the newly developed forms and may incur nominal printing costs if the issuers do not provide forms to the agents, but such costs will not be significant.

11. A description of the Effect on Small Business:

This rule does not have a significant impact on regulated small businesses as defined in s. 227.114 (1), Wis. Stat., including intermediaries. OCI maintains a database of all licensed issuers in Wisconsin. The database includes information submitted by the companies related to premium revenue and employment. In an examination of this database, OCI identified that 75

insurance companies offer Medicare supplement, Medicare cost and Medicare select (Medigap) policies to Wisconsin consumers eligible for Medicare due to age or disability and none of those companies qualify by definition as a small business. In addition, 25 insurance companies have Medigap policyholders although the companies no longer market Medigap coverage in Wisconsin. Again, none of these 25 companies qualifies by definition as a small business. Although affected by this proposed rule change, intermediaries qualifying as small businesses may be affected but such effect will not be significant as previously described.

12. Agency contact person:

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at: **http://oci.wi.gov/ocirules.htm**

or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: inger.williams@wisconsin.gov
Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on the 14th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins 33934
Office of the Commissioner of Insurance
PO Box 7873
Madison WI 53707-7873

Street address:

Julie E. Walsh
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Office of the Commissioner of Insurance
125 South Webster St – 2nd Floor
Madison WI 53703-3474

Email address:

Julie E. Walsh
julie.walsh@wisconsin.gov

Web site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

SECTION 1. Ins 3.39 (5m) (e) (intro.) and 5. are amended to read:

Ins 3.39 (5m) (e) Permissible ~~additional~~ coverage options may only be added to the policy or certificate as separate riders. The issuer shall issue a separate rider for each ~~additional coverage~~ option offered. Issuers shall ensure that the riders offered are compliant with MMA, each rider is priced separately, available for purchase separately at any time, subject to underwriting and the preexisting limitation allowed in sub. (4s) (a) 2 ~~and may~~. The issuer shall not issue to the same insured for the same period of coverage both the Medicare Part A Deductible rider and the Medicare 50% Part A Deductible rider. The issuer shall not issue to the same insured for the same period of coverage both the Medicare Part B Deductible rider and the Medicare Part B Copayment or Coinsurance rider. Separate riders, if offered, shall consist of the following:

5. ~~Coverage of 100% of the Medicare Part B medical deductible~~Medicare Part B Copayment or Coinsurance Rider. ~~The insured is subject to~~ Under this option, the insured's copayment or coinsurance ~~of no more than~~will be the lesser of $20 per office visit or the Medicare Part B coinsurance and ~~no more than~~the lesser of $50 per emergency room visit or the Medicare Part B coinsurance that is in addition to the Medicare Part B medical deductible ~~and in addition to out-of-pocket maximums~~. The emergency room copayment or coinsurance fee shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense. The rider shall be designated as: MEDICARE PART B COPAYMENT OR COINSURANCE ~~DEDUCTIBLE~~ RIDER.

SECTION 2. Ins 3.39 (5m) (k) is created to read:

Ins 3.39 (5m) (k) For the Medicare supplement high deductible plan, the following:

1. The designation: MEDICARE SUPPLEMENT INSURANCE-HIGH DEDUCTIBLE PLAN.

2. Coverage for 100% of benefits described in par. (d), (e) 1., (e) 3., (e) 4., (e) 6., and (e) 7., following the payment of the annual high deductible.

3. The annual high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered in subd. 2 and shall be in addition to any other specific benefit deductibles.

4. The annual high deductible shall be $2000 and shall be adjusted annually by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

SECTION 3. Ins 3.39 (6) and (7) (a) (intro.) are amended to read:

(6) USUAL, CUSTOMARY AND REASONABLE CHARGES. An issuer can only include a policy or certificate provision limiting benefits to the usual, customary and reasonable charge as determined by the issuer for coverages described in subs. (5) (c) 5., 8. and 13, or (5m) (d) ~~5., 8., and 13~~6., 9., and 14. If the issuer includes such a provision, the issuer shall:

(7) (a) (intro.) A Medicare cost policy or certificate issued by an issuer that has a cost contract with CMS for Medicare benefits shall meet the standards and requirements of sub. (4) and shall contain all of the following required coverages, to be referred to as "Basic Medicare cost coverage" for a policy or certificate issued after January 1, 2005~~ with an effective date prior to June 1, 2010~~.

SECTION 4. Ins 3.39 (7) (cm) and (dm) are created amended to read:

(7) (cm) For Medicare cost policies issued on or after June 1, 2010, each Medicare cost issuer, as defined in s. 600.03 (28p) (a) and (c), Stats., may offer an enhanced Medicare cost plan that contain the coverage contained in sub. (5) (d) 6., 7., 8., 10., 14., 16., and 17., and the riders described in sub. (5m) and other coverages as authorized by CMS.

(7) (dm) For Medicare cost policies issued on or after June 1, 2010, in addition to all other subsections that are applicable to Medicare cost policies, the marketing of Medicare cost policies shall comply with the requirements of Medicare supplement policies contained in subs. (15), (21), (24) and (25). The outline of coverage listed in Appendix 2 and the replacement form

specified in Appendix 7 shall be modified to accurately reflect the benefits, exclusions and other requirements that differ from Medicare supplement policies approved under sub. (5m).

SECTION 5. Ins 3.39 (8) (a) (intro.) is amended to read:

(8) (a) (intro.) The coverage set out in subs. (5), (5m), (7), ~~and~~(30) and (30m), as applicable:

SECTION 6. Ins 3.39 (14m) (d) (intro.) is amended to read:

Ins 3.39 (14m) (d) Except as provided in subd. 1., an issuer shall continue to make available for purchase any policy form or certificate form issued after ~~August 1, 1992~~May 31, 2010, that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

SECTION 7. Ins 3.39 (30m) (p) 6. is created to read:

3.39 (30m) (p) 6. Coverage for emergency care obtained outside of the United States as described in sub. (5m) (e) 7.

SECTION 8. Ins 3.39 (30m) (q) is amended to read:

3.39 (30m) (q) Permissible additional coverage may only be added to the policy or certificate as separate riders. The issuer shall issue a separate rider for each additional coverage offered. Issuers shall ensure that the riders offered are compliant with MMA, each rider is priced separately, available for purchase separately at any time, subject to underwriting and the preexisting limitation allowed in sub. (4s) (a) 2., and may consist of the following:

~~1. Coverage for emergency care obtained outside of the United States as described in sub. (5m) (e) 7.~~

~~2~~1. Coverage for 50% of the Medicare Part A hospital deductible with no out-of-pocket maximum as described in sub. (5m) (e) 2.

~~3~~2. Coverage for 100% of the Medicare Part B medical deductible subject to copayment or coinsurance as described in sub. (5m) (e) 5.

SECTION 9. 3.39 (34) (b) 1., (c) 1., (ez) 1., are amended to read:

3.39 (34) (b) *Eligible persons*. An eligible person is an individual described in any of the following subdivisions:

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and the plan does any of the following:

a. Terminates.

b. ~~The plan ceases~~ Ceases to provide some or all such supplemental health benefits to the individual.

c. The amount the individual pays for coverage under the plan increases from one 12-month period to the subsequent 12-month period by more than 25% and the new payment for the employer-sponsored coverage is greater than the premium charged under the Medicare supplement plan for which the individual is applying. An issuer may require reasonable documentation to substantiate the increase of the cost of coverage to the individual. Reasonable documentation that issuers may request includes premium billing statements and notices of premiums from employers for the most recent 12 month period.

(c) *Guaranteed issue time periods*. 1. In the case of an individual described in par. (b) 1., ~~or~~ 1m., or 1s., the guaranteed issue period begins on the later of the following dates:

(ez) 1. Paragraph (b) 1., 1m., 1r., 1s., 2., 3. and 4., is a Medicare supplement policy or certificate as defined in sub. (5m) along with any riders available or a Medicare select policy or certificate as defined in sub. (30m).

SECTION 10. Ins 3.39 (34) (b) 1s., is created to read:

Ins 3.39 (34) (b) 1s. The individual is enrolled in a Medicare select plan and is notified by the issuer as required in par. (f) 3. and s. Ins 9.35, as applicable, that a hospital is leaving the

Medicare select network and that there is no other participating hospital within a 30 minute or 30 mile radius of the policyholder.

SECTION 11. Ins 3.39 (34) (f) 3. is created to read:

3.39 (34) (f) 3. At the time of an event described in par. (b) because of which a hospital in a Medicare select network leaves the network the issuer shall notify the insured of his or her rights under this section, and of the obligations of issuers of Medicare supplement or Medicare cost policies under par. (a). The notice to insureds shall be communicated within 10 business days of the issuer receiving notification of the hospital's notice of leaving the network.

SECTION 12. Ins 3.39 Appendix 3 is amended to read:

Appendix 3

OUTLINE OF COVERAGE

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

(The designation and caption required by sub. (4s) (b) 4.)

MEDICARE SUPPLEMENT PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

Note: Issuers should include only the wording that 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: This includes the Medicare deductibles for Part A and Part B, but does not include [the plan's separate riders deductible.]

Note: Add the following text in a bold or contrasting color if the plan is a Medicare supplement insurance - high deductible plan as defined at sub. (5m) (k): This high deductible plan offers benefits after one has paid a calendar year [$2000] 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 foreign travel emergency deductible.

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
HOSPITALIZATION	First 60 days	All but $	$0 or	

Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	 61st to 90th days 91st day and after while using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	[current deduct-Ible] All but $ [current amount] per day All but $ [current amount] per day $0 $0	[□ OPTIONAL PART A DEDUCTIBLE RIDER* (for non-high deductible plans)] [□ PART A DEDUCTIBLE RIDER* (for high deductible plans)] □ OPTIONAL MEDICARE 50% PART A DEDUCTIBLE RIDER*** $ [current amount] per day $ [current amount] per day 100% of Medicare eligible expenses** $0	
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 21st through 100th day 101st day and after	All approved amounts All but $ [current amount] per day $[0]	$0 Up to $[ ] a day $0	
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	
BLOOD	First 3 pints Additional amounts	$0 100%	First 3 pints $0	
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited coinsurance or copayment for outpatient drugs and inpatient	$0 or [ ]% of coinsurance or copayments	◊

		respite care		

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

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

*** This optional rider may reduce your premium when you pay 50% of Medicare Part A deductible

MEDICARE SUPPLEMENT POLICIES - PART B BENEFITS

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

Note: Add the following text in a bold or contrasting color if the plan is a Medicare supplement insurance-high deductible plan as defined at sub. (5m) (k): This high deductible plan offers benefits after one has paid a calendar year [$2000] 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 foreign travel emergency deductible.

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	[AFTER YOU PAY A $ [ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES Eligible expense for physician's services, in-patient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$ 0 Generally 80%	$0 or [□ OPTIONAL PART B DEDUCTIBLE RIDER** (for non-high deductible plans)] [□ PART B DEDUCTIBLE RIDER**(for high deductible plans)] □ OPTIONAL PART B COPAYMENT OR COINSURANCE ~~DEDUCTIBLE~~ RIDER*** Generally 20% [□ OPTIONAL MEDICARE PART B EXCESS CHARGES RIDER** (for non-high deductible plans)] [□ MEDICARE PART B EXCESS CHARGES RIDER** (for high deductible plans)] [□ OPTIONAL FOREIGN TRAVEL EMERGENCY RIDER** (non-high deductible plans)] [□ FOREIGN TRAVEL	

			EMERGENCY RIDER**(for high-deductible plans)]	
BLOOD	First 3 pints Next $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs [$[ ] (Part B deductible)] 20%	
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	
HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	40 visits or □ OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER**	
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA	First $250 each calendar year Remainder of charges	$0	$250 80% to a lifetime maxi-mum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
[PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.]*	[First $120 each calendar year] [Additional charges]	[$0] [$0]	[$120] [$0] or $[dollar amount]	

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

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

***This is an optional rider that may decrease your premium when you pay copayments for medical and emergency room visits.

SECTION 13. These changes first apply to policies issued or renewed on or after June 1, 2010.

SECTION 14. This section may be enforced under ss. 601.41, 601.64, 601.65, 628.10, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

SECTION 15. These changes 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 _____ day of _____, 2010.

_____
Sean Dilweg
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

for Section Ins 3.39 (34) relating to guarantee issue and affecting small business

This rule change will have no significant effect on the private sector regulated by OCI.