CR 91-10

STATE OF WISCONSIN)
)
OFFICE OF THE COMMISSIONER OF INSURANCE)

I, Robert D. Haase, Commissioner of Insurance and custodian of the official records of this Office, certify that the attached rule-making order affecting ss. Ins 3.39 and 25, Wis. Adm. Code, relating to standards for Medicare supplement policies sold in the State of Wisconsin, was issued by this Office on May 24, 1991.

I further certify that I have compared this copy with the original on file in this Office and that it is a true copy of the whole of the original.

Dated at Madison, Wisconsin, this 24th day of May, 1991.

Robert D. Haase
Commissioner of Insurance

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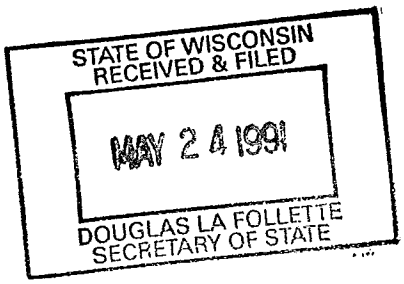

ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

REPEALING, RENUMBERING, RENUMBERING AND AMENDING, AMENDING,

REPEALING AND RECREATING, AND CREATING A RULE

a. To repeal Ins 3.39 (4) (e) 2 to 4, (7) (c) 8 and chapter Ins 25;

b. To renumber Ins 3.39 (4) (e) 5, (7) (a), (b) and (c) (intro.) and 1 to 7, (14) and (27) (a);

c. To renumber and amend Ins 3.39 (7) (intro.) and (d);

d. To amend Ins 3.39 (3) (d), (4) (a) 3, 5 and 7, (e) (intro.) and (f), (5) (c) (intro.), 2 and 4, (i) (intro.), 1 to 5 and 7, (7) (b) 3. c and d, as renumbered, (8) (a) 3, 5, and (b), (11), (16) (a) and (b), (19) (title), (21) (a), (b) and (c), (23) (c), (24) (a) (intro.) and (d), (26) (a) (intro.) and (28) (a) (intro.) and (c);

e. To repeal and recreate Ins 3.39 (3) (c), (5) (c) 8 and Appendix 1; and

f. To create Ins 3.39 (3) (af), (ag), (ah), (ai), (bl), (gl), (gm), (il) and (im), (4) (a) 15 and (e) 2, (4m), (5) (c) 13, (7) (a) and (b) 3. h and i, (14) (a) and (b), (16) (d), (24) (f), (25) (c), and (29),

relating to the standards for Medicare supplement insurance sold in Wisconsin.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3), 625.16, 628.34 (12), 628.38 and 632.81, Stats.

Statutes interpreted: ss. 625.16, 628.34 (12), 628.38 and 632.81, Stats.

This proposed rule amends various sections of the existing rule establishing minimum standards for Medicare supplement policies sold in Wisconsin to conform the discrepancies between the current rule and the model requirements of the National Association of Insurance Commissioners (NAIC), which must be met in order for a state to be certified under federal law to regulate Medicare supplement policies. Most of the changes in this proposed rule incorporate verbatim NAIC language into the Wisconsin rule so that compliance with the requirements of federal law are clearly established.

An emergency rule that includes most of the changes found in this proposed rule is currently in effect.

The substantive changes included in this proposed rule are:

Sections 1 to 4 incorporate various definitions and standards required by the NAIC model. In the NAIC model, these are all classified as definitions.

Section 5 requires that Medicare supplement policies be guaranteed renewable and can only be cancelled for certain specified reasons.

Section 6 requires that insurers must permit midterm cancellation of a Medicare supplement policy by an insured and must issue a pro rata refund upon cancellation.

Sections 7, 8, 9, 25, 26, and 27 clarify the loss ratio requirements as required by the federal certification program.

Section 11 requires insurers to provide an open enrollment period with no underwriting on specified grounds for individuals 65 years of age and older after they first enroll for Medicare Part B benefits as required in the federal law.

Sections 12 and 17 clarify the precise requirements for Medicare supplement policies and Medicare replacement policies for the coverage of skilled nursing facilities for 100 days.

Sections 13, 14, 19 and 20 clarify the requirements for Medicare supplement policies and Medicare replacement policies relating to coverage of chiropractic services and expenses for the treatment of diabetes, coverages required for all disability policies sold in Wisconsin.

Section 15 requires that each permissible additional coverage must be issued as a separate rider and must be priced separately and available for purchase separately.

Sections 18 and 21 permit Medicare cost contracts to vary from the general standards for coverages with the approval of the commissioner of insurance, and requires the availability of an individual policy if the cost contract is terminated.

Section 22 clarifies a requirement that preexisting condition limitations must appear as a separate paragraph on the first page of a policy.

Section 23 deletes the requirement that the booklet health insurance advice for senior citizens need not be given if the booklet for long-term care policies is given in those solicitations.

Section 25 explicitly requires insurers to have only one Medicare supplement policy form in use for each of the categories of individual

policies, Medicare risk contracts and group Medicare supplement policies. It also requires direct refunds and return of premiums to insureds.

Sections 29 and 31 provide that an agent cannot accept first-year compensation that is less than 100% or greater than 150% of renewal compensation in addition to the requirement that an insurer cannot pay such compensation. The amount of a renewal commission must remain the same for at least 5 years. In addition, the rule is amended to provide that only renewal compensation can be paid whenever there is a replacement situation.

Section 32 requires direct mailing of refunds to insureds.

Section 33 imposes new time requirements on agents with respect to forwarding applications and premiums to insurers.

Section 34 clarifies an existing rule to make the annual reporting requirement clear.

Section 37 is a new section required by the NAIC model which requires the filing of out-of-state group policies.

Section 38 revises the appendix containing the outline of coverage to comply with the requirements of the NAIC model by including in the outline under Part B benefits for blood and immunosuppressive drugs and a notice that the insurer will provide annual notice of changes in the policy based on changes in Medicare 30 days prior to the effective date of the Medicare changes.

The proposed rule also makes various technical corrections, including renumbering and spelling, in the existing rule.

The provisions that are already contained in the emergency rule and some others will take effect on the first day of the month after publication of this rule. All other provisions first apply on January 1, 1992.

SECTION 1. Ins 3.39 (3) (af), (ag), (ah), (ai) and (bl) are created to read:

3.39 (3) (af) "Accident," "Accidental Injury" or "Accidental Means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

1. The definition shall not be more restrictive than the following: "'Injury or injuries for which benefits are provided' means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

2. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law or motor vehicle no-fault plan, unless prohibited by law.

(ag) "Applicant" means:

1. In the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits.

2. In the case of a group Medicare supplement policy or subscriber contract, the proposed certificateholder.

(ah) "Certificate" means any certificate issued under a group Medicare supplement policy, which certificate had been delivered or issued for delivery in this state.

(ai) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facilities and available services.

1. A definition of such a home or facility shall not be more restrictive than one requiring that it:

a. Be operated pursuant to law;

b. Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

c. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

d. Provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

e. Maintain a daily medical record of each patient.

2. The definition of such a home or facility may provide that the term does not include:

a. Any home, facility or part of any home or facility used primarily for rest;

b. A home or facility for the care of drug addicts or alcoholics; or

c. A home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

(bl) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

1. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

a. Be an institution operated pursuant to law, and;

b. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which charge is made; and

c. Provide twenty-four (24) hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s).

2. The definition of the term "hospital" may state that the term does not include:

a. Convalescent homes or convalescent, rest or nursing facilities;

b. Facilities primarily affording custodial, educational or rehabilitative care;

c. Facilities for the aged, drug addicts or alcoholics; or

SECTION 2. Ins 3.39 (3) (c) is repealed and recreated to read:

Ins 3.39 (3) (c) "Medicare" shall be defined in the policy. "Medicare" may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

SECTION 3. Ins 3.39 (3) (d) is amended to read:

Ins 3.39 (3) (d) ~~Medicare-approved-expenses"~~ "Medicare eligible expenses" means health care expenses which are covered by Medicare, recognized as medically necessary and reasonable by Medicare, and which may or may not be fully reimbursed by Medicare.

SECTION 4. Ins 3.39 (3) (gl), (gm), (il) and (im) are created to read:

Ins 3.39 (3) (gl) "Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, and mental or emotional disease or disorder of any kind.

(gm) "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as a registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the word "nurse," "trained nurse" or "registered nurse" is used without specific instruction, then the use of the term requires the insurer to recognize the services of any individual who qualified under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(il) "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(im) 1. "Sickness" shall not be defined to be more restrictive than sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.

2. The definition of "sickness" may be further modified to exclude any sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

SECTION 5. Ins 3.39 (4) (a) 3, 5 and 7 and (e) (intro.) are amended to read:

Ins 3.39 (4) (a) 3. Contains no definitions of terms such as "Medicare eligible expenses," "accident," "sickness," "mental or nervous disorders," "skilled nursing facility," "hospital," "nurse," "physician," "Medicare approved expenses," "benefit period," or "outpatient prescription drugs" which are worded less favorably to the insured person than the corresponding Medicare definition or the definitions contained in sub. (3),

and defines "Medicare" as ~~Title-XVIII-of-the-federal-social-security-act-of 1965-as-amended~~ in accordance with sub. (3) (c);"

5. ~~Does-not,-if-the-policy-or-certificate-is-"noncancellable",~~ Is "guaranteed renewable",~~-or-"noncancellable-and-guaranteed-renewable",~~ and does not provide for termination of coverage of a spouse solely because of an event specified for termination of coverage of the insured, other than the nonpayment of premium. The policy shall not be cancelled or nonrenewed by the insurer on the grounds of deterioration of health. The policy may be cancelled for nonpayment of premium or material misrepresentation. If the policy is issued by a health maintenance organization as defined by s. 609.01 (2), Stats., the policy may, in addition to the above reasons, be cancelled or nonrenewed by the insurer if the insured moves out of the service area;

7. Contains statements on the first page and elsewhere in the policy which ~~satisfiy~~ satisfy the requirements of s. Ins 3.13 (2) (c), (d) or (e), and clearly states on the first page or schedule page the duration of the term of coverage for which the policy or certificate is issued and for which it may be renewed;

(e) (intro.) The anticipated loss ratio for ~~the~~ any new policy form, that is, the expected percentage of the aggregate amount of premiums collected which will be returned to insureds in the form of aggregate benefits under the policy form:

SECTION 6. Ins 3.39 (4) (a) 15 is created to read:

Ins 3.39 (4) (a) 15. Provides for midterm cancellation at the request of the insured and that, if an insured cancels a policy midterm or the policy terminates midterm because of the insured's death, the insurer shall issue a pro rata refund to the insured or the insured's estate.

SECTION 7. Ins 3.39 (4) (e) 2 to 4 are repealed.

SECTION 8. Ins 3.39 (4) (e) 2 is created to read:

Ins 3.39 (4) (e) 2. Complies with the loss ratio standards in sub. (16) (d);

SECTION 9. Ins 3.39 (4) (e) 5 is renumbered Ins 3.39 (4) (e) 3.

SECTION 10. Ins 3.39 (4) (f) is amended to read:

Ins 3.39 (4) (f) Except as otherwise provided in this subsection, the terms "Medicare ~~suplement~~ supplement," "medigap" and words of similar import may not be used in a policy or in any advertisement or sales presentation for a policy unless the policy conforms to sub. (5) or (7).

SECTION 11. Ins 3.39 (4m) is created to read:

Ins 3.39 (4m) OPEN ENROLLMENT. Unless the coverage is subject to sub. (7), an insurer may not deny or condition the issuance or effectiveness of, or discriminate in the pricing of, Basic Medicare supplement coverage for which an application is submitted during the 6-month period beginning with the first month in which an individual 65 years of age or older first enrolled for benefits under Medicare Part B on any of the following grounds:

(a) Health status.

(b) Claims experience.

(c) Receipt of health care.

(d) Medical condition.

SECTION 12. Ins 3.39 (5) (c) (intro.), 2 and 4 are amended to read:

Ins 3.39 (5) (c) (intro.) The following required coverages, to be referred to as "Basic Medicare Supplement coverage" for a policy issued after December 31, ~~1988, and before January 1,~~ 1990:

2. Medicare Part A eligible expenses in a skilled nursing facility ~~to the extent not covered by Medicare subject to a maximum benefit of 265 days per benefit period;~~ for the copayments for the 21st through the 100th day.

4. All Medicare Part B ~~approved~~ eligible expenses to the extent not paid by Medicare, including outpatient psychiatric care, subject to the Medicare Part B calendar year deductible;

SECTION 13. Ins 3.39 (5) (c) 8 is repealed and recreated to read:

Ins 3.39 (5) (c) 8. Payment in full for all usual and customary expenses for chiropractic services required by s. 632.87 (3), Stats. Insurers are not required to duplicate benefits paid by Medicare.

SECTION 14. Ins 3.39 (5) (c) 13 is created to read:

Ins 3.39 (5) (c) 13. Payment in full for all usual and customary expenses for treatment of diabetes required by s. 632.895 (6), Stats. Insurers are not required to duplicate expenses paid by Medicare.

SECTION 15. Ins 3.39 (5) (i) (intro.), 1 to 5 and 7 are amended to read:

Ins 3.39 (5) (i) (intro.) Permissible additional coverage which may be ~~included in a Medicare supplement policy or~~ added to the policy as separate riders or amendments. ~~If these coverages are not included in the basic policy, the~~ The insurer shall issue a separate rider for each coverage ~~offered~~ the insurer chooses to offer and each rider shall be priced separately and available for purchase separately.

1. Coverage for the Medicare Part A hospital deductible. ~~If this benefit is included as a rider, then the~~ The rider shall be designated: MEDICARE PART A DEDUCTIBLE RIDER;

2. Coverage for home health care for an aggregate of 365 visits per policy year as required by s. 632.895 (1) and (2). ~~If included as a rider, the~~ The rider shall be designated as: ADDITIONAL HOME HEALTH CARE RIDER;

3. Coverage for the Medicare Part B medical deductible. ~~If included as a rider, the~~ The rider shall be designated as: MEDICARE PART B DEDUCTIBLE RIDER;

4. Coverage for the difference between Medicare's Part B ~~approved~~ eligible charges and the ~~usual, customary and reasonable charges as determined by the insurer. If included as a rider,~~ amount charged by the provider which shall be no greater than the actual charge or the limiting charge allowed by Medicare. The rider shall be designated as: MEDICARE PART B ~~USUAL AND CUSTOMARY~~ EXCESS CHARGES RIDER;

5. Coverage for benefits obtained outside the United States. An insurer which offers this benefit shall not limit coverage to Medicare deductibles and copayments. Coverage may contain a deductible of up to $250. Coverage shall pay at least 80% of reasonable charges. The benefit period ~~must~~ shall be at least 30 days per year. ~~If included as a rider, the~~ The rider shall be designated as: FOREIGN TRAVEL RIDER.

7. At least 75% of the usual and customary charges for outpatient prescription drugs after a deductible of no greater than $100 per year. ~~If issued as a rider, the~~ The rider shall be designated as: OUTPATIENT PRESCRIPTION DRUG USUAL AND CUSTOMARY CHARGES RIDER.

SECTION 16. Ins 3.39 (7) (intro.) is renumbered Ins 3.39 (7) (b) (intro.) and amended to read:

Ins 3.39 (7) (b) (intro.) For a Medicare replacement policy or certificate, other than a policy subject to par. (a), to meet the requirements of sub. (4), it shall contain the authorized designation, caption and minimum required coverage. A health maintenance organization shall place the letters HMO in front of the required designation on any approved Medicare replacement policy. A Medicare replacement policy or certificate shall include:

SECTION 17. Ins 3.39 (7) (a), (b) and (c) (intro.) and 1 to 7 are renumbered Ins 3.39 (7) (b) 1, 2 and 3 (intro.) and a to g and Ins 3.39 (7) (b) 3. c and d, as renumbered, is amended to read:

Ins 3.39 (7) (b) 3. c. Medicare Part A eligible expenses in a skilled nursing facility ~~to the extent not covered by Medicare subject to a maximum benefit of 365 days;~~ for the copayments for the 21st through the 100th day.

d. The Medicare Part B deductible and all Medicare Part B ~~approved~~ eligible expenses, including outpatient psychiatric care, to the extent not covered by Medicare;

SECTION 18. Ins 3.39 (7) (a) is created to read:

Ins 3.39 (7) (a) A policy form issued by an insurer who has a cost contract with Health Care Financing Administration for Medicare Part B benefits shall meet the standards and requirements of subs. (4) and (5), except that the commissioner may, at the request of an insurer, approve variations of the coverages specified under sub. (5).

SECTION 19. Ins 3.39 (7) (c) 8 is repealed.

SECTION 20. Ins 3.39 (7) (b) 3. h and i are created to read:

3.39 (7) (b) 3. h. Payment in full for all usual and customary expenses for chiropractic services required by s. 632.87 (3), Stats. Insurers are not required to duplicate payments made by Medicare.

i. Payment in full for all usual and customary expenses for treatment of diabetes required by s. 632.895 (6), Stats. Insurers are not required to duplicate expenses paid by Medicare.

SECTION 21. Ins 3.39 (7) (d) is renumbered Ins 3.39 (7) (c) and amended to read:

Ins 3.39 (7) (c) ~~The availability of an approved Medicare supplement insurance policy.~~ Each insurer which markets a Medicare replacement policy shall have an approved Medicare supplement insurance policy available for all currently enrolled participants at ~~such~~ the time as the ~~direct risk~~ contract between the Health Care Financing Administration and the insurer is terminated.

SECTION 22. Ins 3.39 (8) (a) 3, 5 and (b) are amended to read:

Ins 3.39 (8) (a) 3. May contain a pre-existing condition waiting period provision as provided in sub. (4) (a) 2~~.~~, which shall appear as a separate paragraph on the first page of the policy and shall be captioned or titled "Pre-existing Condition Limitations;"~~.~~ and

5. May exclude coverage for the treatment of service related conditions for members or ex-member of the armed forces by any military or veterans hospital or soldier home or any hospital contracted for or operated by any national government or agency.

(b) If the insured chooses not to enroll in Medicare Part B, the insurer may exclude from coverage the expenses which Medicare Part B would have covered if the insured were enrolled in Medicare Part B. An insurer may not exclude Medicare Part B ~~approved~~ eligible expenses incurred beyond what Medicare Part B would cover.

SECTION 23. Ins 3.39 (11) is amended to read:

(11) "Health Insurance Advice for Senior Citizens" pamphlet. Every prospective Medicare eligible purchaser of any policy or certificate subject to this section which provides hospital or medical coverage, other than incidentally, or of any coverage added to an existing Medicare supplement policy or certificate, except any policy subject to s. Ins 3.46, shall receive a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" 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). Except in the case of direct response insurance, written acknowledgment of receipt of this pamphlet shall be obtained by the insurer. This pamphlet provides information on Medicare and advice to senior citizens on the purchase of Medicare supplement insurance and other health insurance.

Insurers may obtain information from the commissioner's office on how to obtain copies or may reproduce this pamphlet themselves. This pamphlet may be periodically revised to reflect changes in Medicare and any other appropriate changes. No insurer shall be responsible for providing applicants the revised pamphlet until 30 days after the insurer has been given notice that the revised pamphlet is available.

SECTION 24. Ins 3.39 (14) is renumbered Ins 3.39 (14) (c).

SECTION 25. Ins 3.39 (14) (a) and (b) are created to read:

Ins 3.39 (14) (a) Each insurer may file and utilize only one individual Medicare supplement policy form, one individual Medicare replacement policy form and one group Medicare supplement policy form with any of the accompanying riders permitted in sub. (5) (i), unless the commissioner approves the use of additional forms and the insurer agrees to aggregate experience for the various forms in calculating rates and loss ratios.

(b) An insurer shall mail any refund or return of premium directly to the insured and may not require or permit delivery by an agent or other representative.

SECTION 26. Ins 3.39 (16) (a) and (b) are amended to read:

Ins 3.39 (16) LOSS RATIO REQUIREMENTS FOR EXISTING POLICIES. (a) Every insurer providing Medicare supplement policies in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by number of years of policy duration demonstrating that it is in compliance with the applicable loss ratio standards contained in ~~sub. (4) (e)~~ par. (d) and that the period for which the policy is rated is reasonable in accordance with accepted actuarial principles and experience.

(b) (intro.) For the purposes of this section, a policy shall be deemed to comply with the loss ratio standards if:

1. For the most recent year, the ratio of the incurred losses to earned premiums for policies or certificates which have been in force for ~~three~~ 3 years or more is greater than or equal to the applicable percentages ~~contained in sub. (4) (e)~~ under par. (d); and

2. The expected losses in relation to premiums over the entire period for which the policy is rated comply with the requirements of ~~sub. (4) (e).~~ The par. (d). An expected ~~third-year~~ 3rd-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than ~~three~~ 3 years.

SECTION 27. Ins 3.39 (16) (d) is created to read:

Ins 3.39 (16) (d) For purposes of sub. (4) (e) and par. (b), the loss ratio standards shall be:

1. At least 65% in the case of individual policies.

2. At least 75% in the case of group policies.

SECTION 28. Ins 3.39 (19) (title) is amended to read:

Ins 3.39 (19) (title) FORM AND RATE FILING REQUIREMENTS FOR EXISTING POLICIES.

SECTION 29. Ins 3.39 (21) (a), (b) and (c) are amended to read:

Ins 3.39 (21) COMMISSION LIMITATIONS. (a) An insurer may provide and an agent or other representative may accept commission or other compensation ~~to an agent or other representative~~ for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is at least 100% and no more than ~~150 percent (150%)~~ of the commission or other compensation paid for selling or servicing the policy or certificate in the ~~second~~ 2nd year ~~or period~~.

(b) The commission or other compensation provided in subsequent ~~(~~renewal~~)~~ years ~~must~~ shall be the same as that provided in the ~~second~~ 2nd year or period and ~~must~~ shall be provided for at least ~~five~~ 5 renewal years.

(c) If an existing policy or certificate is replaced, no entity may provide compensation to its ~~other~~ producers and no agent or producer may receive compensation greater than the renewal compensation payable by the replacing insurer on the policy or certificate ~~unless benefits of the new policy or certificate are clearly and substantially greater than the benefits under the replaced policy~~.

SECTION 30. Ins 3.39 (23) (c) is amended to read:

Ins 3.39 (23) (c) Upon determining that a sale will involve replacement, an insurer other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage. One copy of ~~such~~ the notice signed by the ~~applicant~~ applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of the ~~issuance~~ solicitation of the policy the notice regarding replacement of accident and sickness coverage.

SECTION 31. Ins 3.39 (24) (a) (intro.) and (d) are amended to read:

Ins 3.39 (24) (a) (intro.) Every insurer marketing Medicare supplement insurance coverage in this state, ~~directly~~ directly or through its producers, shall:

(d) ~~Establish~~ Every insurer shall establish marketing procedures which set forth a mechanism or formula for determining whether a replacement policy or certificate contains benefits clearly and substantially greater than

the benefits under the replaced policy ~~for purposes of triggering first year commissions as authorized in sub. (21)~~.

SECTION 32. Ins 3.39 (24) (f) is created to read:

Ins 3.39 (24) (f) If an insured exercises the right to return a policy during the free look period, the insurer shall mail the entire premium refund directly to the person who paid the premium.

SECTION 33. Ins 3.39 (25) (c) is created to read:

Ins 3.39 (25) (c) An agent shall forward each application taken for a Medicare supplement policy to the insurer within 7 calendar days after taking the application. An agent shall mail the portion of any premium collected due the insurer to the insurer within 7 days after receiving the premium.

SECTION 34. Ins 3.39 (26) (a) (intro.) is amended to read:

Ins 3.39 (26) (a) (intro.) On or before March 1 of each year, every insurer providing Medicare supplement insurance coverage in this state shall report the following information for every individual resident of this state for which the insurer has in force more than one Medicare supplement insurance policy or certificate:

SECTION 35. Ins 3.39 (27) (a) is renumbered Ins 3.39 (27).

SECTION 36. Ins 3.39 (28) (a) (intro.) and (c) are amended to read:

Ins 3.39 (28) (a) (intro.) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in ~~sub.~~ par. (c), the insurer shall offer certificateholders at least the following choices:

(c) If a group Medicare supplement policy is replaced by another group Medicare supplement policy, the ~~sueeeding~~ succeeding insurer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any

limitation for preexisting conditions that would have been covered under the group policy being replaced.

SECTION 37. Ins 3.39 (29) is created to read:

Ins 3.39 (29) Every insurer of group Medicare supplement insurance benefits to a resident of this state shall file a copy of the master policy and any certificate used in this state in accordance with the filing requirements and procedures applicable to group Medicare supplement policies issued in this state; provided, however, that no insurer shall be required to make a filing earlier than 30 days after insurance was provided to a resident of this state under a master policy issued for delivery outside this state.

SECTION 38. Ins 3.39 Appendix 1 is repealed and recreated to read:

APPENDIX 1

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

or

OUTLINE OF MEDICARE REPLACEMENT INSURANCE

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

(1) Read Your Policy Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. READ YOUR POLICY CAREFULLY!

(2) (a) The outline of coverage for a Medicare supplement insurance policy shall contain the following language:

Medicare Supplement Insurance Policy: This policy supplements Medicare. It covers some hospital, skilled nursing facility, medical, surgical, and other outpatient services which are partially covered by Medicare. It will not cover all your health care expenses. 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.

(b) The outline of coverage for a Medicare replacement insurance policy shall contain the following language:

Medicare Replacement Insurance Policy: This policy provides basic Medicare hospital and physician benefits. It also includes benefits beyond those provided by Medicare. This policy is a replacement for 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 supplement policies marketed by intermediaries:

Neither (Insert company's name) nor its agents are connected with Medicare.

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

(Insert company's name) is not connected with Medicare.

(c) For Medicare replacement policies:

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

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

(b) For Medicare replacement policies, provide a brief summary of both the basic 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 SUPPLEMENT POLICIES--PART A BENEFITS
(Insurers should include only the wording which applies to their policy's "This Policy Pays" column and complete the "You Pay" column)

MEDICARE PART A BENEFITS	PER BENEFIT PERIOD	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
Hospitalization. Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. Includes meals, special care units,	First 60 days	All but $(current deductible)	$0 or ($) __ or /_/ OPTIONAL PART A DEDUCTIBLE RIDER*	
drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services.	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 care in a facility approved by Medicare. Confinement must meet Medicare standards. You must have been in a hospital for at least three days and enter the facility within 30 days after discharge.	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	

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

MEDICARE PART A BENEFITS	PER BENEFIT PERIOD	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
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 365 visits or /__/ OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER*	

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

MEDICARE SUPPLEMENT POLICIES--PART B BENEFITS

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
Medical expenses. Eligible expenses for physician's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy, ambulance, and outpatient psychiatric care	Initial ($) deductible	$0	Nothing or ($) __ or /__/ OPTIONAL PART B DEDUCTIBLE RIDER*	
	After initial deductible	80% of Medicare approved charge	20% of Medicare approved charge or The difference between what Medicare pays and the excess charge __ or /__/ OPTIONAL MEDICARE PART B EXCESS CHARGES RIDER*	
Outpatient prescription drugs		$0	$0 or 75% of outpatient prescription drugs with a deductible of $_____ (not more than $100) __ or /__/ OPTIONAL OUTPATIENT PRESCRIPTION DRUG USUAL AND CUSTOMARY CHARGES RIDER*	
Blood		80% of costs except nonreplacement fees (blood deductible) for first 3 pints (after $_____ deductible/ calendar year)	20% of all costs and the first 3 pints in each calendar year	

Immunosuppressive drugs	80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after $_____ deductible/ calendar year)	20% of allowable charges for immunosuppressive drugs
Part B policy limits per calendar year		No limit

*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 care 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.

(6) Conspicuous statements as follows:

(a) The chart summarizing Medicare benefits only briefly describes such benefits.

(b) The federal Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.

(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 POLICY

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 what Medicare pays and the amount charged by the provider which shall be no greater than the actual charge or the limiting charge allowed by Medicare, whichever is less

$( ) 5. Usual and customary outpatient prescription drug charges

75% of the usual and customary charges after a deductible of $_____ (no more than $100)

$( ) 6. Foreign travel rider

After a deductible of not greater than $250, covers at least 80% of expenses associated with medical care received outside the U.S.A. for a minimum of 30 days

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$( ) 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.)

IN ADDITION TO THIS OUTLINE OF COVERAGE, [INSURANCE COMPANY] WILL SEND AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE 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 insurer shall give a separate schedule of premiums for each rating classification with the outline of coverage.

(13) A summary of or reference to the coverage required by applicable statutes.

(14) The term "certificate" shall be substituted for the word "policy" throughout the outline of coverage where appropriate.

SECTION 39. Chapter Ins 25 is repealed.

SECTION 40. INITIAL APPLICABILITY. (1) Except as provided in subdivision (2), this rule first applies on the effective date of this rule.

(2) Section Ins 3.39 (4m), (5) (c) 8 and 13 and (i) (intro.), 1 to 5 and 7, (7) (except (7) (c) 3, as renumbered), and, (16) (a), (b), and (d), as affected by this rule, first apply to policies issued on or after on January 1, 1992.

SECTION 41. EFFECTIVE DATE. This rule takes effect on the first day of the first month after publication, as provided in s. 227.24 (2) (intro.), Stats.

Dated at Madison, Wisconsin, this 24th day of May, 1991.

Robert D. Haase
Commissioner of Insurance

678R29
04/03/91