CR 93-107

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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STATE OF WISCONSIN RECEIVED & FILED
APR 8 1994
DOUGLAS LA FOLLETTE
SECRETARY OF STATE

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

I, Josephine W. Musser, Commissioner of Insurance and custodian of the official records of this Office, certify that the attached rule-making order affecting sections Ins 3.39, Wis. Adm. Code relating to the sale of Medicare supplement insurance in Wisconsin, was issued by this Office on April 5, 1994.

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, on April 5, 1994.

Josephine W. Musser
Commissioner of Insurance

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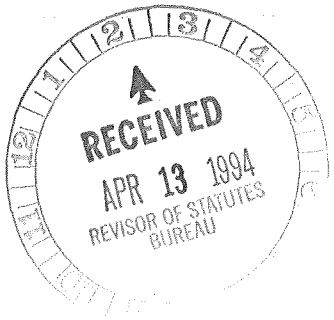
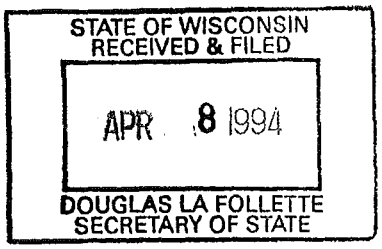




ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

REPEALING, AMENDING AND CREATING A RULE

To repeal Ins 3.39 (2) (d) 2; to amend Ins 3.39 (3) (al); (4) (a) 1., 5., 7., 15., 16. and 18.; (4) (b) 1.; (4m) (a); (5) (c) 5., 6., 8. and 13.; (5) (i) (intro.); (5) (i) 5.; (6) (intro.); (7) (a); (7) (b) 3. e., f., h. and i.; (7) (c); (7) (d) 2.; (8) (b); (10) (a), (b), (c) and (d) 1.; (11); (14) (a) and (b); (14) (i) and (j); (15); (16) (c); (16) (c) 1.; (21) (a) and (c); (22) (b); (23) (b), (bl), (c) and (d); (24) (a) (intro.); (24) (b); (24) (c) 1. and 3.; (24) (f); (25) (c); (26) (a); (27); (28) (a) (intro.); (28) (b) (intro.); (28) (c); (30) (c); (30) (i) 1.; (30) (p) 7.; Appendix 1 (chart title); and Appendix 1 (4) (c) (Part B Benefits chart), (11), (12) and Appendix 6; to create Ins 3.39 (5) (c) 15.; (7) (b) 3. j.; (7) (e); (14) (k), (l) and (m); (23) (e); (30) (i) 9, and (30) (p) 8., and to renumber Ins 3.39 (23) (b) [second paragraph (b)] relating to the sale of Medicare supplement insurance 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.

Most of the changes in this rule for Medicare supplement insurance sold to Medicare eligible persons merely substitute the word "issuers" for the word "insurers" or make other technical changes. The Health Care Financing Administration (HCFA) required these changes to obtain federal certification.

The sections which have other changes are:

SECTION 1. Repeal an exception for certain association groups and thus require those forms to comply with the rule.

SECTION 5. Clarifies that the renewal period consists of the greater of the period paid for, the period specified in the policy, or three months.

SECTION 9. Requires insurers to allow individuals to have an open enrollment for a Medicare supplement policy whenever the individual first enrolls in Medicare Part B, even if they are under or over age 65, and allows individuals enrolled in HIRSP and who were enrolled in Medicare Part B when they were under age 65 to be subject to the open enrollment when they turn 65.

SECTIONS 10, 16 and 18. Clarifies that the state-mandated benefits for home health care can contain a usual and customary limitation.

SECTIONS 13, 19 and 52. Requires that the basic Medicare supplement policy pay at least 80% of all outpatient prescription drugs after a drug deductible of no more than $6,250 per calendar year. This benefit will coordinate with the existing outpatient prescription drug rider currently available.

SECTION 14. Requires that the riders be available for purchase at any time.

SECTION 27. Allows the insurer to waive the incontestable period instead of requiring other evidence of insurability for applicants 75 or older.

SECTION 28. Requires insurers to offer the current Medicare supplement policy without waiting periods or underwriting to any individual whose nonguaranteed renewable Medicare supplement policy is nonrenewed by the insurer, requires insurers to pool the

Wisconsin experience for certain or all policies issued before January 1, 1992, in calculating the loss ratios and requires insurers to use Medicare's determination of eligibility.

SECTION 36. Allows the insurer to use an application with health questions for open enrollment applicants, if the application states that the health questions are not to be answered if the applicant is in the open enrollment period.

SECTION 1. Ins 3.39 (2) (d) 2 is repealed.

SECTION 2. Ins 3.39 (3) (al) is amended to read:

Ins 3.39 (3) (al) "Health Care Expense" means expenses of health maintenance organizations associated with the delivery of health care services which expenses are analogous to incurred losses of ~~insurers~~ issuers. Such expenses shall not include:

1. Home office and overhead costs;

2. Advertising costs;

3. Commissions and other acquisition costs;

4. Taxes;

5. Capital costs;

6. Administrative costs; and

7. Claims processing costs.

SECTION 3. Ins 3.39 (4) (a) 1 is amended to read:

Ins 3.39 (4) (a) 1. Provides only the coverage set out in sub. (5), (7) or (30) and applicable statutes and contains no exclusions or limitations other than those permitted by sub. (8). After being notified by the commissioner in writing that the Federal Department of Health and Human Services has approved the Wisconsin Medicare supplement regulatory program including the Medicare Select program in section (30), no ~~insurer~~ issuer may

issue an HMO Medicare supplement policy under sub. (5) and all HMO Medicare supplement policies must be written in accordance with sub. (30).

SECTION 4. Ins 3.39 (4) (a) 5 is amended to read:

Ins 3.39 (4) (a) 5. Is "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~~ issuer on the grounds of deterioration of health. The policy may be cancelled only 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~~ issuer if the insured moves out of the service area;

SECTION 5. Ins 3.39 (4) (a) 7 is amended to read:

Ins 3.39 (4) (a) 7. Contains statements on the first page and elsewhere in the policy which 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 (the renewal period cannot be less than the greater of three months, the period for which the insured has paid the premium or the period specified in the policy);

SECTION 6. Ins 3.39 (4) (a) 15. and 16. are amended 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~~ issuer shall issue a pro rata refund to the insured or the insured's estate.

16. Except for permitted preexisting condition clauses as described in subd. ~~14.~~ 2., no policy or certificate may be advertised, solicited or

issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

SECTION 7. Ins 3.39 (4) (a) 18 is amended to read:

Ins 3.39 (4) (a) 18. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period not to exceed 24 months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the ~~insurer~~ issuer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

SECTION 8. Ins 3.39 (4) (b) 1 is amended to read:

Ins 3.39 (4) (b) 1. Is provided to all applicants at the time application is made and, except in the case of direct response insurance, the ~~insurer~~ issuer obtains written acknowledgement from the applicant that the outline was received;

Section 9. Ins 3.39 (4m) (a) is amended to read:

Ins 3.39 (4m) (a) Unless the coverage is subject to sub. (7), an ~~insurer~~ issuer may not deny or condition the issuance or effectiveness of, or discriminate in the pricing of, basic Medicare supplement coverage, Medicare Select policies permitted under sub (30) or riders permitted under sub. (5) (i) for which an application is submitted during the 6-month period beginning with the first month in which an individual ~~65-year-of-age-or-older~~ first

enrolled for benefits under Medicare Part B or the month in which an individual turns age 65 for any individual who was first enrolled in Medicare Part B when under the age of 65 and enrolled in the Health Insurance Risk Sharing Plan under s. 619.11, Stats. on any of the following grounds:

1. Health status

2. Claims experience

3. Receipt of health care

4. Medical condition

SECTION 10. Ins 3.39 (5) (c) 5 and 6 are amended to read:

Ins 3.39 (5) (c) 5. Payment of the usual and customary home ~~Home~~ care ~~benefits~~ expenses to a minimum of 40 visits per 12-month period as required under s. 632.895 (1) and (2), Stats., and s. Ins 3.54;

6. Nursing home confinement and ~~confinement,~~ kidney disease ~~treatment, and diabetes expense coverage~~ as required under s. 632.895 (3) and ~~(3),~~ (4) and ~~(6)~~, Stats.;

SECTION 11. Ins 3.39 (5) (c) 8 is amended 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~~ Issuers are not required to duplicate benefits paid by Medicare;

SECTION 12. Ins 3.39 (5) (c) 13 is amended 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~~ Issuers are not required to duplicate expenses paid by Medicare.

Section 13. Ins 3.39 (5) (c) 15. is created to read:

Ins 3.39 (5) (c) 15. Coverage for at least 80% of the charges for outpatient prescription drugs after a drug deductible of no more than $6,250 per calender year.

SECTION 14. Ins 3.39 (5) (i) (intro.) is amended to read:

Ins 3.39 (5) (i) (intro.) Permissible additional coverage only added ~~only if coverage is~~ to the policy as separate riders ~~or amendments~~. The ~~insurer~~ issuer shall issue a separate rider for each coverage the ~~insurer~~ issuer chooses to offer and each rider shall be priced separately, available for purchase separately at any time, subject to underwriting and the preexisting limitation allowed in sub. (4) (a) 2., ~~and available for purchase~~ separately and may consist only of the following:

SECTION 15. Ins 3.39 (5) (i) 5 is amended to read:

Ins 3.39 (5) (i) 5. "Coverage for benefits obtained outside the United States." An ~~insurer~~ issuer 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 the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during at least the first 60 consecutive days of each trip outside the United States and a lifetime maximum benefit of at least $50,000. For purposes of this benefit, "emergency hospital, physicians and medical care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset. The rider shall be designated as: FOREIGN TRAVEL RIDER.

SECTION 16. Ins 3.39 (6) (intro.) is amended to read:

Ins 3.39 (6) (intro.) USUAL, CUSTOMARY AND REASONABLE CHARGES. An issuer can only include a policy provision limiting benefits to the usual,

customary and reasonable charge as determined by the issuer for coverages described in ~~subds.~~ subs. (5) (c) 5., 8. and 13 and (7) (b) 3. e., h. and i. If the issuer includes such a provisions, the issuer shall:

SECTION 17. Ins 3.39 (7) (a) is amended to read:

Ins 3.39 (7) (a) A policy form issued by an ~~insurer~~ issuer who has a cost contract with the 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~~ issuer, approve variations of the coverages specified under sub. (5).

SECTION 18. Ins 3.39 (7) (b) 3. e., f., h. and i. are amended to read:

Ins 3.39 (7) (b) 3. e. ~~Home~~ Payment of the usual and customary home care ~~benefits~~ expenses to a minimum of 40 visits per 12-month period as required under s. 632.895 (1) and (2), Stats., and s. Ins 3.54;

f. Nursing home ~~confinement,~~ confinement and kidney disease treatment~~, and diabetes~~ expense coverage as required under s. 632.895 ~~(3),~~ (3) and (4) ~~and (6)~~, Stats.;

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

SECTION 19. Ins 3.39 (7) (b) 3. j. is created to read:

Ins 3.39 (7) (b) 3. j. Coverage for at least 80% of the charges for outpatient prescription drugs after a drug deductible of no more than $6,250 per calendar year.

SECTION 20. Ins 3.39 (7) (c) is amended to read:

(c) Each ~~insurer~~ issuer which markets a Medicare replacement policy shall have an approved Medicare supplement insurance policy or Medicare Select policy available for all currently enrolled participants at the time as the contract between the Health Care Financing Administration and the ~~insurer~~ issuer is terminated.

SECTION 21. Ins 3.39 (7) (d) 2 is amended to read:

Ins 3.39 (7) (d) 2. The Medicare replacement policy may require requests for disenrollment to be in writing. Enrollees may not be required to give their reasons for disenrolling, or to consult with an agent or other representative of the ~~insurer~~ issuer before disenrolling.

SECTION 22. Ins 3.39 (7) (e) is created to read:

Ins 3.39 (7) (e) Each issuer shall offer the rider as described in sub. (5) (i) 2. and may offer the other riders described in sub. (5) (i) and other coverages as authorized by the Health Care Financing Administration.

SECTION 23. Ins 3.39 (8) (b) is amended to read:

Ins 3.39 (8) (b) If the insured chooses not to enroll in Medicare Part B, the ~~insurer~~ issuer may exclude from coverage the expenses which Medicare Part B would have covered if the insured were enrolled in Medicare Part B. An ~~insurer~~ issuer may not exclude Medicare Part B eligible expenses incurred beyond what Medicare Part B would cover.

SECTION 24. Ins 3.39 (10) (a), (b), (c) and (d) 1. are amended to read:

Ins 3.39 (10) (a) Conversion requirements. An insured under individual, family, or group hospital or medical coverage who will become eligible for Medicare and is offered a conversion policy which is not subject

to subs. (4) and (5) or (7) shall be furnished by the ~~insurer~~ issuer, at the time the conversion application is furnished in the case of individual or family coverage or within 14 days of a request in the case of group coverage:

1. An outline of coverage as described in par. (d) and

2. A copy of the current edition of the pamphlet described in sub. (11).

(b) Continuation requirements. An insured under individual, family, or group hospital or medical coverage who will become eligible for Medicare and whose coverage will continue with changed benefits (e.g., "carve-out" or reduced benefits) shall be furnished by the ~~insurer~~ issuer, within 14 days of a request:

1. A comprehensive written explanation of the coverage to be provided after Medicare eligibility, and

2. A copy of the current edition of the pamphlet described in sub. (11).

(c) Notice to group policyholder. An ~~insurer~~ issuer which provides group hospital or medical coverage shall furnish to each group policyholder:

1. Annual written notice of the availability of the materials described in pars. (a) and (b), where applicable, and

2. Within 14 days of a request, sufficient copies of the same or a similar notice to be distributed to the group members affected.

(d) 1. For a conversion policy which relates its benefits to or complements Medicare, shall comply with sub. (4) ~~(e)~~ (b) 2., 5. and 7. of this section and shall be submitted to the commissioner; and

SECTION 25. Ins 3.39 (11) is amended to read:

Ins 3.39 (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" in a type size no smaller than 12-point type at the time the prospect is contacted by an intermediary or ~~insurer~~ issuer with an invitation to apply as defined in s. Ins 3.27 (5) (g). Except in the case of direct response insurance, written acknowledgement of receipt of this pamphlet shall be obtained by the ~~insurer~~ issuer. This pamphlet provides information on Medicare and advice to senior citizens on the purchase of Medicare supplement insurance and other health insurance. ~~Insurers~~ Issuers 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~~ issuer shall be responsible for providing applicants the revised pamphlet until 30 days after the ~~insurer~~ issuer has been given notice that the revised pamphlet is available.

SECTION 26. Ins (14) (a) and (b) are amended to read:

Ins 3.39 (14) (a) Each ~~insurer~~ issuer 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~~ issuer agrees to aggregate experience for the various forms in calculating rates and loss ratios.

(b) An ~~insurer~~ issuer 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 27. Ins 3.39 (14) (i) and (j) are amended to read:

Ins 3.39 (14) (i) No ~~insurer~~ issuer may issue a Medicare supplement policy or a certificate to an applicant 75 years of age or older, unless the applicant is subject to sub. (4m) ~~or~~ or, prior to issuing coverage, the ~~insurer~~ issuer either agrees not to rescind or void the policy except for intentional fraud in the application, or obtains one of the following:

1. A copy of a physical examination.

2. An assessment of functional capacity.

3. An attending physician's statement.

4. Copies of medical records.

(j) Notwithstanding sub. (a), an ~~insurer~~ issuer may file and use only one individual Medicare Select policy form and one group Medicare Select policy form. These policy forms shall not be aggregated with non-Medicare Select forms in calculating premium rates, loss ratios and premium refunds.

SECTION 28. Ins 3.39 (14) (k), (l) and (m) are created to read:

Ins 3.39 (14) (k) If an issuer nonrenews an insured who has a nonguaranteed renewable Medicare supplement policy with the issuer, the issuer shall at the time any notice of nonrenewal is sent to the insured, offer a currently available individual replacement Medicare supplement policy and those currently available riders resulting in coverage substantially similar to coverage provided by the replaced policy without underwriting. This replacement shall comply with sub. (27).

(L) For policies issued between December 31, 1980, and January 1, 1992, issuers shall combine the Wisconsin experience of all policy forms of the same type (individual or group) for the purposes of calculating the loss

ratio under sub. (16) (c) and rates. The rates for all such policies of the same type shall be adjusted by the same percentage. Issuers may combine the Wisconsin experience of all policies issued prior to January 1, 1981, with those issued between December 31, 1980, and January 1, 1992, if the issuer uses the 60% loss ratio for individual policies and the 70% loss ratio for group policies. If the Wisconsin experience is not credible, then national experience can be considered.

(m) If Medicare determines the eligibility of a covered service, then the issuer must use Medicare's determination in processing claims.

SECTION 29. Ins 3.39 (15) is amended to read:

Ins 3.39 (15) FILING REQUIREMENTS FOR ADVERTISING. Prior to use in this state, every ~~insurer~~ issuer shall file with the commissioner a copy of any advertisement used in connection with the sale of Medicare supplement policies issued with an effective date after December 31, 1989. If the advertisement does not reference a particular ~~insurer~~ issuer or Medicare supplement policy, each agent utilizing the advertisement shall file the advertisement with the commissioner prior to using it. ~~Insurers~~ Issuers and agents shall submit the advertisements using forms specified in Appendices 2 and 3. The advertisements shall comply with all applicable laws and rules of this state.

SECTION 30. Ins 3.39 (16) (c) is amended to read:

Ins 3.39 (16) (c) As soon as practicable, but no later than October 1 of the year prior to the effective date of enhancements in Medicare benefits, every ~~insurer~~ issuer providing Medicare supplement policies or certificates in this state shall file with the commissioner in accordance with the applicable filing procedures of this state appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the current premium for the

applicable policies or certificates. Supporting documents as necessary to justify the adjustment shall accompany the filing.

SECTION 31. Ins 3.39 (16) (c) 1 is amended to read:

Ins 3.39 (16) (c) 1. Every ~~insurer~~ issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the ~~insurer~~ issuer for such Medicare supplement insurance policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date.

SECTION 32. Ins 3.39 (21) (a) is amended to read:

Ins 3.39 (21) (a) An ~~insurer~~ issuer may provide and an agent or other representative may accept commission or other compensation 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% of the commission or other compensation paid for selling or servicing the policy or certificate in the 2nd year.

SECTION 33. Ins 3.39 (21) (c) is amended to read:

Ins 3.39 (21) (c) If an existing policy or certificate is replaced, no entity may provide compensation to its producers and no agent or producer may receive compensation greater than the renewal compensation payable by the replacing ~~insurer~~ issuer on the policy or certificate.

SECTION 34. Ins 3.39 (22) (b) and (23) (b), (b), (c) and (d) are amended to read:

Ins 3.39 (22) (b) Except for riders or endorsements by which the ~~insurer~~ issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement insurance policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

3.39 (23) (b) Agents shall list, in a supplementary form signed by the agent and submitted to the ~~insurer~~ issuer with each application for Medicare supplement coverage, any other health insurance policies they have sold to the applicant as follows:

1. Any policy sold which is still in force.

2. Any policy sold in the past 5 years which is no longer in force.

(b) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the ~~insurer~~ issuer, shall be returned to the applicant by the ~~insurer~~ issuer upon delivery of the policy.

(c) Upon determining that a sale will involve replacement, an ~~insurer~~ issuer, other than a direct response ~~insurer~~ issuer, 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 in no less than 10 point type. One copy of the notice signed by the 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~~ issuer. A direct response ~~insurer~~ issuer shall deliver to the applicant at the time of the solicitation of the policy the notice regarding replacement of accident and sickness insurance.

(d) The notice required by par. (c) for an ~~insurer~~ issuer shall be provided in substantially the form as shown in Appendix 5.

SECTION 35. Ins 3.39 (23) (b) [the second (b) paragraph] is renumbered 3.39 (23) (bL).

SECTION 36. Ins 3.39 (23) (e) is created to read:

Ins 3.39 (23) (e) If the application contains questions regarding health, include a statement that health questions should not be answered if the applicant is in the open-enrollment period described in s. (4m).

SECTION 37. Ins 3.39 (24) (a) (intro.) is amended to read:

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

SECTION 38. Ins 3.39 (24) (b) is amended to read:

(b) Every ~~insurer~~ issuer marketing Medicare supplement insurance shall establish auditable procedures for verifying compliance with par. (a).

SECTION 39. Ins 3.39 (24) (c) 1 is amended to read:

Ins 3.39 (24) (c) 1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or ~~insurers~~ issuers for the purpose of inducing, or tending to

induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another ~~insurer~~ issuer.

SECTION 40. Ins 3.39 (24) (c) 3 is amended to read:

Ins 3.39 (24) (c) 3. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose is solicitation of the purchase of insurance and that contact will be made by an agent or ~~insurer~~ issuer.

SECTION 41. Ins 3.39 (24) (f) is amended to read:

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

SECTION 42. Ins 3.39 (25) (c) is amended to read:

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

SECTION 43. Ins 3.39 (26) (a) is amended to read:

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

1. Policy and certificate number, and

2. Date of issuance.

SECTION 44. Ins 3.39 (27) is amended to read:

Ins 3.39 (27) WAITING PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing ~~insurer~~ issuer shall waive any time periods applicable to pre-existing condition waiting periods in the new Medicare supplement policy to the extent time was satisfied under the original policy or certificate.

SECTION 45. Ins 3.39 (28) (a) (intro.) is 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 par. (c), the ~~insurer~~ issuer shall offer certificate holders at least the following choices:

SECTION 46. Ins 3.39 (28) (b) (intro.) is amended to read:

Ins 3.39 (28) (b) (intro.) If membership in a group is terminated, the ~~insurer~~ issuer shall:

SECTION 47. Ins 3.39 (28) (c) is amended to read:

Ins 3.39 (28) (c) If a group Medicare supplement policy is replaced by another group Medicare supplement policy, the succeeding ~~insurer~~ issuer 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 pre-existing conditions that would have been covered under the group policy being replaced.

SECTION 48. Ins 3.39 (30) (c) is amended to read:

Ins 3.39 (30) (c) The commissioner may authorize an ~~insurer~~ issuer to offer a Medicare select policy or certificate, pursuant to this subsection and section 4358 of the Omnibus Budget Reconciliation Act ~~(ORBA)~~ (OBRA) of 1990, if the commissioner finds that the issuer has satisfied all of the

requirements of this subsection.

SECTION 49. Ins 3.39 (30) (i) 1 is amended to read:

Ins 3.39 (30) (i) 1. An outline of coverage in substantially the same format as Appendix 1 sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

a. Other Medicare supplement policies or certificates offered by the issuer; and

b. Other Medicare Select policies or certificates.

SECTION 50. Ins 3.39 (30) (i) 9 is created to read:

Ins 3.39 (30) (i) 9. The caption, except that the word "certificate" may be used instead of "policy," if appropriate: "The Wisconsin Insurance Commissioner has set standards for Medicare Select policies. This policy meets these standards. It, along with Medicare, may not cover all of your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see 'Health Insurance Advice for Senior Citizens,' given to you when you applied for this policy. Do not buy this policy if you did not get this guide."

SECTION 51. Ins 3.39 (30) (p) 7. is amended to read:

Ins 3.39 (30) (p) 7. Coverage for preventive health care services as described in ~~see.--(5)-(i)-6.~~ sub. (5) (c) 14.

SECTION 52. Ins 3.39 (30) (p) 8. is created to read:

Ins 3.39 (30) (p) 8. Coverage for at least 80% of the charges for outpatient prescription drugs after a drug deductible of no more than $6,250 per calendar year.

SECTION 53. Ins 3.39 Appendix 1 (chart title) is amended to read:

MEDICARE SUPPLEMENT POLICIES--PART A BENEFITS
(~~Insurers~~ Issuers should include only the wording which applies to their policy's "This Policy Pays" column and complete the "You Pay" column)

SECTION 54. Ins 3.39 Appendix 1 (4) (c) (Part B Benefits chart), (11), (12) and Appendix 6 are amended to read:

Ins 3.39 Appendix 1 (4) (c) Part B Benefits Chart)

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, in-patient and out-patient medical services and	Initial ($) deductible	$0	Nothing ~~or~~ ~~($---)~~ __ or /__/ OPTIONAL PART B DEDUCT-IBLE RIDER*	
supplies at a hospital, physical and speech therapy, ambulance, and outpatient psychiatric care	After initial deductible	80% of Medicare ~~approved~~ eligible charge	20% of Medicare ~~approved~~ eligible charge __ ~~or~~ and /__/ OPTIONAL MEDICARE PART B EXCESS CHARGES RIDER*	
Outpatient prescription drugs	Initial $6,250 deductible	$0	~~$0~~ 80% of charges over $6,250 __ ~~or~~ and /__/ OPTIONAL OUTPATIENT PRESCRIPTION DRUG RIDER*	
Blood		80% of costs except non-replacement fees (blood deductible) for first 3 pints (after $_____ deductible/ calendar year	20% of all eligible costs and the first 3 pints in each calendar year	

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.

(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 the Medicare ~~pays~~ eligible charge and the amount charged by the ~~physician~~ provider which shall be no greater than the limiting charge allowed by Medicare

$( ) 5. Outpatient prescription drug charges

At least 50% of the charges after a deductible of $_____ (no more than $250) to a maximum benefit of $--------(~~no less than $3,000~~) $3,000 per year.

$( ) 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. during the first 60 days of a trip with a maximum of at least $50,000

$( ) TOTAL FOR BASIC POLICY AND SELECTED OPTIONAL BENEFITS

(Note: The soliciting agent shall enter the appropriate premium amounts and the total at the time this outline is given to the applicant.)

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.

(Note: Medicare Select policies shall modify the outline to reflect the benefits which are contained in the policy and the optional rider and shall substitute the designation "Medicare Select Policy" for Medicare Supplement Insurance.)

(12) If premiums for each rating classification are not listed in the outline of coverage under subsection (11), then the ~~insurer~~ issuer shall give a separate schedule of premiums for each rating classification with the outline of coverage.

Ins 3.39 Appendix 6

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR ____

TYPE _____ SMSBP (w) [form number] _____

for the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Person Completing This Exhibit _____

Title _____ Telephone Number _____

Line		(a) Earned Premium (x)	(b) Incurred Claims (y)
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues ~~(2)~~ (z)		
	c. Net (for reporting purposes = 1a-1b)	_____	_____
2.	Past Years' Experience (All policy Years)	_____	_____
3.	Total Experience (net Current Year + Past Years' Experience)	_____	_____
4.	Refunds last year (Excluding Interest)	_____	
5.	Previous refunds since Inception (Excluding Interest)	_____	
6.	Refunds Since Inception (Excluding Interest) (add lines 4 and 5)	_____	
7.	Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1)	_____	
8.	Experience Ratio Since Inception		

$$\text{Ratio 2} = \frac{\text{Total Actual Incurred Claims (line 3, col b)}}{\text{Total. Earned Prem. (line 3, col a) - Refunds Since Inception (line 6)}}$$

9. Life Years Exposed since Inception _____

If the Experience Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10. Tolerance Permitted (obtained from credibility table) _____

11. Adjustment to Incurred Claim for Credibility

Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than Benchmark Ratio (ratio 1) a refund or credit to premium is not required.

If Ratio 3 is less than the Benchmark Ratio, then proceed.

12. Adjusted Incurred Claims =

[Tot. Earned Premiums (line 3, col a)-Refunds Since Inception (line 6)]

x Ratio 3 (line 11)

13. Refund = Total Earned Premiums (line 3, col a) - Refunds Since Inception (line 6) - $\frac{\text{Adjusted Incurred Claims (line 12)}}{\text{Benchmark Ratio (Ratio 1)}}$

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 - 9,999	5.0
2,500 - 4,999	7.5
1,000 - 2,499	10.0
500 - 999	15.0

If less than 500, no credibility.

(w) "SMSBP" = Standardized Medicare Supplement Benefit Plan
For Wisconsin reports, show the applicable policy form number.
~~(k)~~ (x) Includes modal loadings and fees charged
(y) Excludes Active Life Reserves
(z) This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title

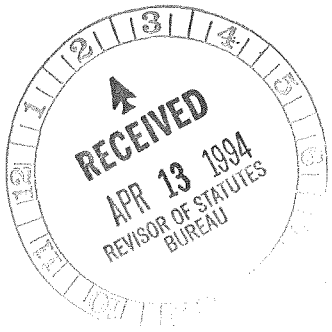
_____
Date

SECTION 55. INITIAL APPLICABILITY. This rule first applies to any policy issued, renewed or solicited on or after September 1, 1994.

SECTION 56. EFFECTIVE DATE. This rule will take effect on September 1, 1994.

Dated at Madison, Wisconsin, this 5th day of April, 1994.

Josephine W. Musser
Commissioner of Insurance



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04/04/94

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Josephine W. Musser
Commissioner

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REPORT ON s. Ins 3.39, Relating to
the sale of Medicare Supplement insurance in Wisconsin
Submitted Under s. 227.19 (3), Stats.

A proposed rule-making order of the Commissioner of Insurance is attached.

(a) Statement of need for the proposed rule

This rule is being amended in order to have the Wisconsin Medicare Supplement program certified by HCFA. Additional changes, described in the analysis, are being made to strengthen and clarify the rule.

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

There were very few changes after the hearing. The changes made were technical ones where "insurer" was used instead of "issuer" and technical changes recommended by the Legislative Council.

(c) Persons who appeared or registered for or against the proposed rule, or for information:

Appearances:

For:

Marjorie Groom	Elder Law Center & Coalition of Wisconsin Aging Groups
Jeffrey Spitzer-Resnick	
Geralyn Hawkins	Wisconsin Board on Aging

Against:

Penny Siewart	Blue Cross Blue Shield United of WI
Tom Mack	Aid Assosciation for Lutherans
Joyce Lane	United American Ins. Co.
Eugene Volk	Banker's Life & Casualty Co.

For Information:

Jo Adams	Wisconsin Physiciains Service Ins. Corp.

Registrations:

For:
None

Against:
None

Neither for nor against:

Mary Haffenbredl	Association of HMOs
Ellen Diedrichsen	American Family Ins
Jim Gatz	American Family Insurance
Laura Evangelista	AARP & Prudential Ins Companies
Dotti Outland	AARP & Prudential Ins Companies
Lisa Hilbert	Health Insurance Association of America

Letters received:

Barbara Van Dam	Blue Cross Blue Shield United of WI
Tom Mack	Aid Association for Lutherans
Robert Shapland	Mutual of Omaha
Laurie Gruba	Banker's Life & Casualty Company
Robert Wood	Wisconsin Physicians Service Ins. Corp.
Barbara Thoni	Coalition of Wisconsin Aging Groups
Geralyn Hawkins	Board on Aging
Daniel Edge	DeanCare HMO
Jeffery Spitzer-Resnick	
Mary Haffenbredl	Association of Wisconsin HMOs

(d) Response to Legislative Council staff recommendations

All comments were complied with and corrected except the following:

5b. It is very difficult to do this type of description and would not to add to the analysis

5n. This part of the rule is unchanged from the current version.

(e) Regulatory flexibility analysis

1. None of the methods specified under s. 227.14 (2), Stats., for reducing the rule's impact on small businesses were included because all must be treated equally and thus it is not possible to have different rules for one segment of the population.

2. No issues were raised by small businesses during the hearing on the proposed rule.

3. The proposed rule does not impose any additional reporting requirements on small businesses.

4. The proposed rule does not require any additional measures or investments by small businesses.

5. No methods specified under s. 227.114 (2), Stats., are included in the proposed rule.

6. No methods specified under s. 227.114 (2), Stats., are included in the proposed rule.

(f) Fiscal Effect

See fiscal estimate attached to proposed rule.

February 4, 1994