



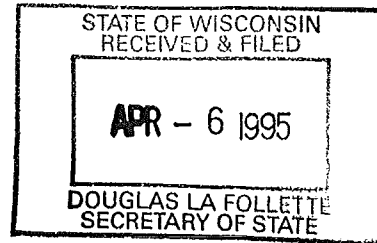
CR 94-223

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Josephine W. Musser
Commissioner

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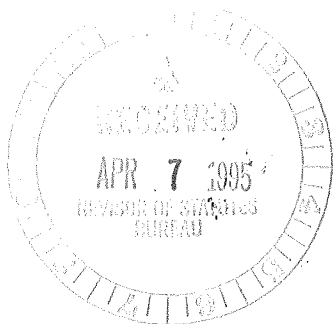


STATE OF WISCONSIN)
)
OFFICE OF THE COMMISSIONER OF INSURANCE)

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(7)(b)3. d., h. and k. and (7)(f), Wis. Adm. Code relating to the requirements for medicare risk contracts sold in Wisconsin to allow certain co-pays by the insured, was issued by this Office on April 6, 1995.

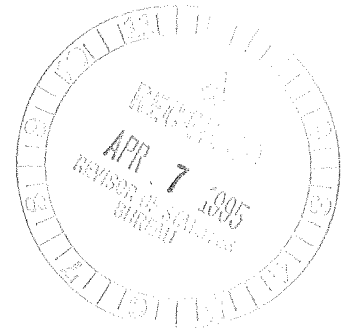
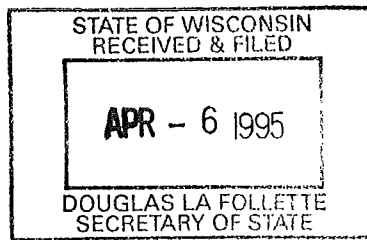
I further certify that I have compared this copy with the original on file in this Office and that it is a true copy of the whole of the original.

Dated at Madison, Wisconsin, on April 6, 1995.



Josephine W. Musser
Josephine W. Musser
Commissioner of Insurance

6-1-95



ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

AMENDING AND CREATING A RULE

To amend Ins 3.39 (7) (b) 3. d. and h.; and to create Ins 3.39 (7) (b) 3. k. and (7) (f) relating to the requirements for medicare risk contracts sold in Wisconsin.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

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

Statutes interpreted: ss. 600.03, 628.34 (12), and 632.81, Stats.

These changes would allow entities who hold a risk contract with Health Care Financing Administration (HCFA) to charge a copayment of up to \$20 per office visit and up to \$40 for any emergency room visit which does not result in admission to a hospital and make clear that these policies are subject to the same marketing regulations as medicare supplement policies.

SECTION 1. Amend s. Ins 3.39 (7) (b) 3. d. and h. to read:

Ins 3.39 (7) (b) 3. d. The medicare part B deductible and all medicare part B eligible expenses, including inpatient psychiatric care, to

the extent not covered by medicare. The issuer may impose a copayment of not more than \$20 per office visit for this benefit;

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 and may impose a copayment of not more than \$20 per office visit for this benefit;

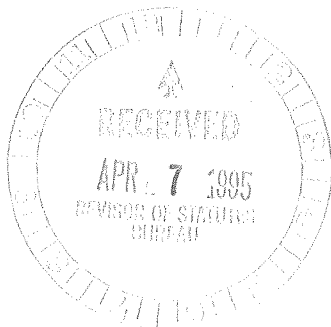
SECTION 2. Create Ins 3.39 (7) (b) 3. k. and (7) (f) to read:

Ins 3.39 (7) (b) 3. k. The issuer may require a copayment by the insured of not more than \$40 for each hospital emergency room visit at an affiliated provider if the patient is not admitted to a hospital within 24 hours of the emergency room treatment

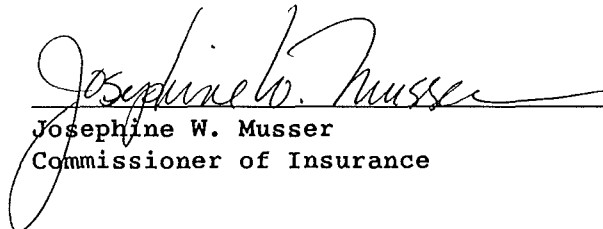
Ins 3.39 (7) (f). In addition to all other subsections which are applicable to medicare replacement policies, the marketing of medicare replacement policies shall comply with the requirements of medicare supplement policies contained in subs. (15), (21), (23), (24), and (25). The outline of coverage listed in appendix 1 and the replacement form specified in appendix 5 shall be modified to accurately reflect the benefit, exclusions and other requirements which differ from medicare supplement policies approved under sub. (5).

SECTION 3. EFFECTIVE DATE. This rule will take effect on the first day of the month after publication, as provided in s. 227.22 (2) (intro.), Stats.

Dated at Madison, Wisconsin, this 6th day of April, 1995.



845R2
04/06/95


Josephine W. Musser
Commissioner of Insurance