CR 81-241



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

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Thomas R. Hefty, Deputy Commissioner of Insurance and custodian of the official records of said office, do hereby certify that the annexed order repealing, renumbering, amending and repealing and recreating rules relating to standards for disability insurance sold to the Medicare eligible was issued by this office May 21, 1982.

I further certify that said copy has been compared by me with the original on file in this office and that the same is a true copy thereof, and of the whole of such original.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name in the City of Madison, State of Wisconsin, this 21st day of May, 1982.

Thomas R. Hefty
Deputy Commissioner of Insurance

1412C

ORDER OF THE COMMISSIONER OF INSURANCE

REPEALING, RENUMBERING AND AMENDING, AMENDING, REPEALING AND RECREATING, AND CREATING RULES

To repeal section Ins 3.29 (3) (j); renumber and amend section Ins 3.29 (7); amend sections Ins 3.13 (2) (j) 3 and 3.29 (3) (a) and (i); repeal and recreate section Ins 3.39; and create sections Ins 3.29 (7) (b) and 3.46 (3) (c) of the Wisconsin Administrative Code; relating to standards for disability insurance sold to the Medicare eligible.

ANALYSIS PREPARED BY

THE OFFICE OF THE COMMISSIONER OF INSURANCE

The purpose of section Ins 3.39 is to establish standards for disability insurance sold the Medicare eligible. Since the rule was first adopted in 1977, this subject has been reviewed by the National Association of Insurance Commissioners (NAIC) and the federal government. The main purpose of the proposed amendments is to make Wisconsin's regulation of Medicare supplement policies as strict as the NAIC model regulatory program. If this is not done by July 1, 1982, the federal government is authorized under 42 U.S.C. s. 1395ss to certify certain Medicare supplement policies sold to Wisconsin residents.

The revised sections interpret and implement sections 185.983 (1m), 601.01 (2), 625.16, 628.34 (12), 628.38, 631.20 (2), 632.73 (2m), 632.76 (2) (b) and 632.81, Stats. Some of the interpreted statutes were affected or created by Ch. 82, Laws of 1981.

Section Ins 3.39 is revised to apply to certain group policies and certificates as well as individual policies. Medicare supplements are allowed to use waiting periods for pre-existing conditions of no more than six months, and pre-existing conditions may not be defined more restrictively than conditions for which a physician was consulted within six months before the effective date of the policy. The anticipated loss ratio for Medicare supplements must be at least 60% in the case of individual and mass-marketed group policies, and at least 75% in the case of other group policies.

Section Ins 3.39 retains 3 levels of Medicare supplements. A Medicare supplement 3 must provide at least the minimum coverage recommended by the NAIC. The other two categories are revised to meet the NAIC standards and reflect changes in Medicare. A Medicare supplement 1 provides the most comprehensive coverage, including coverage for the difference between Medicare's allowable charge for a service and the provider's usual and customary charge.

Certain individual policies are required to bear captions if they are sold to people eligible for Medicare. Section Ins 3.39 (8), dealing with conversion or continuation of coverage, is extensively revised for clarity.

Section Ins 3.39 continues the requirement that every Medicare eligible purchaser of a Medicare supplement policy must receive an outline of coverage and the buyer's guide, Health Insurance Advice for Senior Citizens, before the application is taken. In addition, the

buyer's guide must be furnished at the time of application for an individual accident and sickness policy sold to a person over 65, even if the policy is not a Medicare supplement.

The revisions exempt certain Medicare supplement policies from the special requirements for pre-existing conditions provisions and right to return provisions set forth in s. 632.73 (2m) and 632.76 (2) (b), Stats.

Section Ins 3.13 (2) (j) 3, relating to the right to return a policy, is amended to reflect a statutory change. Section Ins 3.29, relating to replacement of disability insurance, is amended to meet the standards for Medicare supplements recommended by the NAIC.

Section Ins 3.46, relating to standards for nursing home insurance, is amended to provide that nursing home coverage included in a hospital confinement indemnity policy must meet the standards in that section, if the policy is sold to a person eligible for Medicare.

Pursuant to the authority vested in the Commissioner by sections 185.983 (1m), 601.01 (2), 625.16, 628.34 (12), 628.38, 631.20 (2), 632.73 (2m), 632.76 (2) (b) and 632.81, Wisconsin Statutes, the Commissioner of Insurance hereby interprets and implements sections 185.983 (1m), 601.01 (2), 625.16, 628.34 (12), 628.38, 631.20 (2), 632.73 (2m), 632.76 (2) (b), and 632.81, Wisconsin Statutes, by repealing section Ins 3.29 (3) (j); renumbering and amending section Ins 3.29 (7); amending sections Ins 3.13 (2) (j) 3 and 3.29 (3) (a) and (i); repealing and recreating section Ins 3.39; and by creating sections Ins 3.29 (7) (b) and 3.46 (3) (c) of the Wisconsin Administrative Code as follows:

SECTION 1. Section Ins 3.13 (2) (j) 3. is amended to read:

Ins 3.13 (2) (j) 3. provide an unrestricted right to return the policy, within 10 days from the date it is received by the policyholder, to the insurer at its home or branch office, if any, or to the agent through whom it was purchased; except it shall provide an unrestricted right to return the policy within 30 days of the date it is received by the policyholder in the case of a Medicare supplement policy subject to s. Ins 3.39 (4), (5), and (6), Wis. Adm. Code, issued pursuant to a direct response solicitation. Provision shall not be made to require the policyholder to set out in writing the reasons for returning the policy, to require the policyholder to first consult with an agent of the insurer regarding the policy, or to limit the reasons for return.

SECTION 2. Section Ins 3.29 (3) (a) and (i) are amended to read:

Ins 3.29 (3) (a) Group, blanket or group type, except Medicare supplement insurance subject to s. Ins 3.39 (4), (5), and (6), Wis. Adm. Code,

Ins 3.29 (3) (i) Conversion to an individual or family policy to replace group, blanket or group type coverage in the same insurer;.

SECTION 3. S. Ins 3.29 (3) (j) is repealed.

SECTION 4. S. Ins 3.29 (7) is renumbered s. 3.29 (7) (a) and amended to read:

Ins 3.29 (7) (a) Notice to applicant. The notice required by subsection (6) shall provide, in substantially the following form:

NOTICE TO APPLICANT

REGARDING REPLACEMENT OF ACCIDENT AND

SICKNESS INSURANCE

According to (your application) (the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by _____ Insurance Company. For your own information and protection, certain facts should be pointed out to you which should be considered before you make this change.

1. Health conditions which you may presently have may not be covered under the new policy. This could result in a claim for benefits being denied which may have been payable under your present policy. (This language may be modified if pre-existing conditions are covered under the new policy.)

2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective. (This language may be modified if pre-existing conditions are covered under the new policy.)

3. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.

4. The new policy will be issued at a higher age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.

5. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.

6. It may be to your advantage to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. You should be certain that you understand all the relevant factors involved in replacing your present coverage.

The above "Notice to Applicant" was delivered to me on _____.

(date)

_____

Applicant

SECTION 5. S. Ins 3.29 (7) (b) is created to read:

Ins 3.29 (7) (b) The notice required by subsection (6) for a Medicare supplement policy subject to s. Ins 3.39 (4), (5), and (6), Wis. Adm. Code, shall include an introductory statement in substantially the following form: Your new policy provides _____ days within which you may decide without cost whether you desire to keep the policy.

SECTION 6. Section Ins 3.39 is repealed and recreated to read:

Ins 3.39 STANDARDS FOR DISABILITY INSURANCE SOLD TO THE MEDICARE ELIGIBLE. (1) PURPOSE. (a) This section establishes minimum requirements for disability insurance which may be sold to Medicare eligible persons as Medicare supplement coverage. A policy or certificate will be approved by the commissioner as a Medicare supplement if it provides the required coverage and if it contains the designation and caption appropriate to that level of coverage. A policy or certificate that is designed, structured, or intended as a supplement to

Medicare will be disapproved pursuant to s. 631.20, Stats., if that policy does not meet the minimum requirements of any of the 3 levels of coverage set out in sub. (5). Disclosure provisions are also established for other disability policies sold to Medicare eligible persons, because such policies have frequently been represented to, and purchased by, the Medicare eligible as supplements to Medicare.

(b) This section seeks to reduce abuses and confusion associated with the sale of disability insurance to Medicare eligible persons by providing for clearly defined categories of Medicare supplement insurance and reasonable minimum levels of coverage for each category. The disclosure requirements and categories established are intended to provide to Medicare eligible persons guidelines that can be used to compare Medicare supplement insurance policies and certificates on the market and to aid them in the purchase of Medicare supplement insurance which is suitable for their needs. This section is designed not only to improve the ability of the Medicare eligible consumer to make an informed choice when purchasing a Medicare supplement policy or certificate, but also to assure the Medicare eligible persons of this state that no policy or certificate will be approved by the commissioner as a "Medicare supplement" unless it contains coverage which warrants the use of that label.

(c) Wisconsin statutes interpreted and implemented by this rule are ss. 185.983 (1m), 601.01 (2), 625.16, 628.34 (12), 628.38, 631.20 (2), 632.73 (2m), 632.76 (2) (b) and 632.81.

(2) SCOPE. This section applies to individual and group disability policies sold to Medicare eligible persons as follows:

(a) Except as provided in pars. (d) and (e), subs. (4), (5), (6), and (9) apply to any group or individual Medicare supplement policy as defined in s. 600.03 (35) (e), Stats., including:

1. Any Medicare supplement policy issued by a voluntary nonprofit sickness care plan subject to ch. 185, Stats.

2. Any certificate issued under a group Medicare supplement policy;

3. Any individual or group policy sold predominantly to the Medicare eligible which offers hospital, medical, surgical, or other disability coverage, except for a policy which offers solely nursing home, hospital confinement indemnity, or specified disease coverage; and

4. Any conversion contract offered to a Medicare eligible person, if the prior individual or group policy includes no provision inconsistent with the requirements of this section.

(b) Except as provided in pars. (d) and (e), subs. (7) and (9) apply to any individual disability policy sold to a person eligible for Medicare which is not a Medicare supplement as described in par. (a).

(c) Except as provided in par. (e), sub. (8) applies to:

1. Any conversion policy which is offered to a person eligible for Medicare as a replacement for prior individual or group hospital or medical coverage, other than a Medicare supplement policy described in par. (a); and

2. Any individual or group hospital or medical policy which continues with changed benefits after the insured becomes eligible for Medicare.

(d) Except as provided in sub. (8) and (11), this section does not apply to:

1. A group policy issued to one or more employers or labor organizations, or to the trustees of a fund established by one or more employers or labor organizations, or a combination of both, for employes or former employes or both, or for members or former members or both of the labor organizations;

2. A group policy issued to any professional, trade, or occupational association for its members, former members, retired members, or a combination of these if the association:

a. Is composed of individuals all of whom are or had been actively engaged in the same profession, trade, or occupation;

b. Has been maintained in good faith for purposes other than obtaining insurance; and

c. Has been in existence for at least two years prior to the date of its initial offering of the policy to its members, former members, or retired members;

3. Individual or group hospital, surgical, medical, major medical, or comprehensive medical expense coverage which continues after an insured becomes eligible for Medicare; or

4. A conversion contract offered to a Medicare eligible person as a replacement for prior individual or group hospital, surgical, medical, major medical, or comprehensive medical expense coverage, if the prior policy includes provisions which are inconsistent with the requirements of this section.

(e) This section does not apply to:

1. A policy providing solely accident, dental, vision, disability income, or credit disability income coverage; or

2. A single premium, non-renewable policy.

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

(a) "Medicare" means the hospital (Part A) and medical (Part B) insurance program established by title XVIII of the federal social security act of 1965, as amended; that is, 42 USC 1395 to 1395ss.

(b) "Medicare eligible persons" includes all persons who qualify for Medicare by reason of age.

(c) "Medicare eligible expenses" means health care expenses of the type covered by Medicare, to the extent recognized as medically necessary by Medicare, and, except as provided in sub. (5) (a) 3 f, to the extent recognized as reasonable by Medicare, which may or may not be fully reimbursed by Medicare. "Medicare Part A eligible expenses" means Medicare eligible expenses covered under Medicare Part A, and "Medicare Part B eligible expenses" means Medicare eligible expenses covered under Medicare Part B.

(d) "Medicare supplement coverage" means coverage which meets the definition in s. 600.03 (35) (e), Stats., as interpreted by sub. (2) (a), and which conforms to subs. (4), (5), and (6).

(e) "Hospital confinement indemnity coverage" means coverage as defined in s. Ins 3.27 (4) (b) 6, Wis. Adm. Code.

(f) "Specified disease coverage" means coverage which is limited to named or defined sickness conditions. The term does not include dental or vision care coverage.

(g) "Nursing home coverage" means coverage as described in s. Ins 3.46 (3), Wis. Adm. Code.

(h) "Outline of coverage" means a printed statement which meets the requirements of s. Ins 3.27 (5) (1), Wis. Adm. Code, and of sub. (4) (b).

(i) Terms such as "skilled nursing facility" and "benefit period" used in this section shall be as defined by Medicare.

(4) MEDICARE SUPPLEMENT POLICY OR CERTIFICATE REQUIREMENTS. No disability insurance policy or certificate comprehended by this section shall relate its coverage to Medicare or be structured, advertised, or marketed as a supplement to Medicare unless:

(a) The policy or certificate:

1. Provides at a minimum the coverage set out in sub. (5) and applicable statutes, and contains no exclusions or limitations other than those permitted by sub. (6);

2. Contains no pre-existing condition waiting period longer than six months, and does not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

3. Contains no definitions of terms such as "skilled nursing facility", "hospital", "nurse", "physician", "Medicare eligible expenses", or "benefit period" which are worded less favorably to the insured person than the corresponding Medicare definition, and contains as a definition of the term, "Medicare", "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", "Title I, Part I of Public Law 39-97, 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;

4. Does not indemnify against losses resulting from sickness on a different basis from losses resulting from accident; and

5. Does not if the policy or certificate is "noncancellable", "guaranteed renewable", or "noncancellable and guaranteed renewable", 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;

6. Provides that termination of the policy or certificate shall be without prejudice to a continuous loss which commenced while the policy or certificate was in force, although the extension of benefits may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits;

7. Contains a renewal, continuation, or nonrenewal provision, on the first page of the policy or certificate, which satisfies the requirements of s. Ins 3.13 (2) (c), (d) and (e), Wis. Adm. Code, and clearly states the duration of the term of coverage for which the policy or certificate is issued and for which it may be renewed;

8. Provides that benefits designed to cover cost sharing amounts under Medicare shall be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors, although there may be a corresponding modification of premiums in accordance with the policy provisions and Ch. 625, Stats., and;

9. Is approved by the commissioner.

(b) The policy in the case of an individual policy, or the certificate in the case of a group policy:

1. Contains in close conjunction on its first page the designation, printed in 18-point type of a style in general use, and the

caption, printed in 12-point type of a style in general use, prescribed in sub. (5); and

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

(c) The outline of coverage for the policy or certificate:

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

2. Complies with s. Ins 3.27 (5) (1) and s. Ins 3.27 (9) (u), (v) and (zh) 2 and 4, Wis. Adm. Code;

3. Is substituted so as to properly describe the policy or certificate when it is issued, if the outline provided at the time of application does not properly describe the coverage which was issued, and the substituted outline accompanies the policy or certificate when it is delivered and contains the following statement, in no less than 12-point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.";

4. Contains in close conjunction on its first page the designation, printed in a distinctly contrasting color in 24-point type of a style in general use, and the caption, printed in a distinctly contrasting color in 18-point type of a style in general use, prescribed in sub. (5);

5. Is in the format prescribed in the appendix to this section;

6. Summarizes or refers to the coverage set out in applicable statutes; and

7. Is approved by the commissioner along with the policy or certificate form.

(d) Any rider or endorsement added to the policy or certificate:

1. Shall be set forth in the policy or certificate and, if a separate, additional premium is charged in connection with the rider or endorsement the premium charge shall be set forth in the policy or certificate; and

2. After the date of policy or certificate issue, shall be agreed to in writing signed by the insured, if the rider or endorsement increases benefits or coverage with an accompanying increase in premium during the term of the policy or certificate, unless the increase in benefits or coverage is required by law.

(e) The anticipated loss ratio for the 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:

1. Is computed on the basis of anticipated incurred claims and earned premiums as estimated for the entire period for which rates are computed to provide coverage, in accordance with accepted actuarial principles and practices;

2. Is at least 60 percent in the case of individual policies;

3. Is at least 60 percent in the case of group policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising;

4. Is at least 75 percent in the case of group policies other than those described in subd. 3; and

5. Is approved by the commissioner along with the policy form.

(5) AUTHORIZED MEDICARE SUPPLEMENT POLICY OR CERTIFICATE DESIGNATIONS, CAPTIONS, AND MINIMUM COVERAGES. For a policy or certificate to meet the requirements of sub. (4), it shall contain the authorized designation, caption and minimum coverage prescribed for one of the following categories of Medicare supplement insurance.

(a) A MEDICARE SUPPLEMENT 1 policy or certificate shall include:

1. The following designation: MEDICARE SUPPLEMENT 1

2. The following caption, except that the word "certificate" may be used in the last two sentences instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for Medicare supplement policies. There are three types. A Medicare supplement 1 offers the most protection. A Medicare supplement 3 offers the least protection. For an explanation, 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.

3. The following minimum coverage: This level of coverage shall at a minimum cover all expenses listed below.

a. Medicare Part A eligible expenses for hospitalization, including inpatient psychiatric care, to the extent not covered by Medicare from the 61st through the 90th day in any Medicare benefit period;

b. Medicare Part A eligible expenses for hospitalization, including inpatient psychiatric care, to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

c. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days or the maximum coverage for inpatient psychiatric care, all Medicare Part A eligible expenses for hospitalization not covered by Medicare, including inpatient psychiatric care, subject to a maximum benefit of at least an additional 365 days per Medicare benefit period;

d. Medicare Part A eligible expenses for extended care services in a skilled nursing facility to the extent not covered by Medicare subject to a maximum benefit per Medicare benefit period of at least 365 days;

e. All Medicare Part A eligible expenses for blood to the extent not covered by Medicare;

f. All usual and customary charges for Medicare Part B eligible expenses, except outpatient psychiatric care, to the extent not covered by Medicare regardless of hospital confinement, based upon the insurer's determination of usual and customary charges in the area in which the expenses are incurred, subject to a maximum benefit of at least $7,500 per calendar year;

g. At least 75% of usual and customary charges for prescription drugs based upon the insurer's determination of usual and customary charges in the area in which the expenses are incurred, subject to the $7,500 calendar year maximum benefit for Medicare Part B eligible expenses; and

h. At least 50% of usual and customary charges for outpatient psychiatric treatment expenses, based upon the insurer's determination of usual and customary charges in the area in which the expenses are incurred, up to a lifetime maximum of at least $1,000, which may be

applied to the $7,500 calendar year maximum benefit for Medicare Part B eligible expenses.

(b) A MEDICARE SUPPLEMENT 2 policy or certificate shall include:

1. The following designation: MEDICARE SUPPLEMENT 2

2. The following caption, except that the word "certificate" may be used in the last two sentences instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for Medicare supplement policies. There are three types. A Medicare supplement 1 offers the most protection. A Medicare supplement 3 offers the least protection. For an explanation, 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.

3. The following minimum coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below.

a. Medicare Part A eligible expenses for hospitalization, including inpatient psychiatric care, to the extent not covered by Medicare from the 61st through the 90th day in any Medicare benefit period;

b. Medicare Part A eligible expenses for hospitalization, including inpatient psychiatric care, to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

c. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days or the maximum coverage for inpatient psychiatric care, all Medicare Part A eligible expenses for hospitalization not covered by Medicare, including inpatient psychiatric care, subject to a lifetime maximum benefit of at least an additional 365 days;

d. Medicare Part A eligible expenses for extended care services in a skilled nursing facility to the extent not covered by Medicare subject to a maximum benefit per Medicare benefit period of at least 365 days; and

e. All Medicare Part B eligible expenses, except outpatient psychiatric care, to the extent not covered by Medicare regardless of hospital confinement, subject to a maximum benefit of at least $5,000 per calendar year.

(c) A MEDICARE SUPPLEMENT 3 policy or certificate shall include:

1. The following designation: MEDICARE SUPPLEMENT 3

2. The following caption, except that the word "certificate" may be used in the last two sentences instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for Medicare supplement policies. There are three types. A Medicare supplement 1 offers the most protection. A Medicare supplement 3 offers the least protection. For an explanation, 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.

3. The following minimum coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below.

a. Medicare Part A eligible expenses for hospitalization, excluding inpatient psychiatric care, to the extent not covered by Medicare from the 61st through the 90th day in any Medicare benefit period;

b. Medicare Part A eligible expenses for hospitalization, excluding inpatient psychiatric care, to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

c. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, at least 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, excluding inpatient psychiatric care, subject to a lifetime maximum benefit of at least an additional 365 days; and

d. At least 20% of all Medicare Part B eligible expenses, except outpatient psychiatric care, regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5,000 per calendar year.

(6) PERMISSIBLE MEDICARE SUPPLEMENT POLICY OR CERTIFICATE EXCLUSIONS AND LIMITATIONS.

(a) The coverages set out in sub. (5) may:

1. Exclude expenses for which the insured is compensated by Medicare;

2. Exclude coverage for the initial deductibles for Medicare Parts A and B;

3. Include any exclusion or condition contained in Medicare, except that Medicare supplements 1 and 2 shall cover inhospital treatment of mental illness the same as any other illness;

4. Contain an appropriate provision relating to the effect of other insurance on claims;

5. Contain a pre-existing condition waiting period provision as provided in sub. (4) (a) 2., which shall appear as a separate paragraph of the policy and shall be captioned or titled "Pre-existing Condition Limitations"; and

6. If issued by a voluntary nonprofit sickness care plan subject to chapter 185, Stats., include territorial limitations which are generally applicable to all coverage issued by the plan.

(b) Where the insured chooses not to enroll in Medicare Part B, the insurer may exclude from coverage the expenses which Medicare Part B would cover. Medicare Part B eligible expenses incurred beyond what Medicare Part B would cover may not be excluded.

(c) The coverages set out in sub. (5) may not exclude, limit, or reduce coverage for specifically named or described pre-existing diseases or physical conditions, except as provided in par. (a) 5.

(d) A policy or certificate subject to sub. (5) which provides benefits for "usual", "reasonable", or "customary" charges, or charges described in similar terms, shall contain a definition of the terms and its outline of coverage shall explain the terms.

(7) INDIVIDUAL POLICIES PROVIDING NURSING HOME, HOSPITAL CONFINEMENT INDEMNITY, SPECIFIED DISEASE AND OTHER COVERAGES. (a) Caption requirements. Captions required by this subsection shall be:

1. Printed and conspicuously placed on the first page of the Outline of Coverage,

2. Printed on a separate form attached to the first page of the policy, and

3. Printed in 18-point bold letters.

(b) Nursing home coverage. An individual policy form providing nursing home coverage subject to s. Ins 3.46, Wis. Adm. Code which is sold to a Medicare-eligible persons shall bear the following caption: This policy's nursing home benefits are not related to Medicare. For more information, see "Health Insurance Advice for Senior Citizens", given to you when you applied for this policy.

(c) Hospital confinement indemnity coverage. An individual policy form providing hospital confinement indemnity coverage sold to a Medicare eligible person:

1. Shall not include benefits for nursing home confinement unless the nursing home coverage meets the standards set forth in s. Ins 3.46, Wis. Adm. Code; and

2. Shall bear the following caption, if the policy provides no other types of coverage: This policy is not designed to fill the gaps in Medicare. It will pay you only a fixed dollar amount per day when you are confined to a hospital. For more information, see "Health Insurance Advice for Senior Citizens", given to you when you applied for this policy.

3. Shall bear the caption set forth in par. (e), if the policy provides other types of coverage in addition to the hospital confinement indemnity coverage.

(d) Specified disease coverage. An individual policy form providing benefits only for one or more specified diseases sold to a Medicare eligible person shall bear:

1. The following designation: SPECIFIED OR RARE DISEASE LIMITED POLICY, and

2. The following caption: This policy covers only one or more specified or rare illnesses. It is not a substitute for a broader policy which would generally cover any illness or injury. For more information, see "Health Insurance Advice for Senior Citizens", given to you when you applied for this policy.

(e) Other coverage. An individual disability policy sold to a Medicare eligible person, other than a form subject to sub. (5) or otherwise subject to the caption requirements in this subsection or exempted by sub. (2) (d) or (e), shall bear the following caption: This policy is not a Medicare supplement. For more information, see "Health

Insurance Advice for Senior Citizens", given to you when you applied for this policy.

(f) Use of terms. Except as otherwise provided in this subsection, the terms "Medicare Supplement", "Medigap" and words of similar import shall not be used in a policy or in any advertisement or sales presentation for a policy, unless the policy conforms to sub. (4).

(8) CONVERSION OR CONTINUATION OF COVERAGE. (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), (5), and (6) shall be furnished by the insurer, 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. (9).

(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, 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. (9).

(c) Notice to group policyholder. An insurer 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) Outline of coverage. The outline of coverage:

1. For a conversion policy which relates its benefits to or complements Medicare, shall comply with sub. (4) (c) 2., 5. and 6. of this section and shall be submitted to the commissioner; and

2. For a conversion policy not subject to subd. 1., shall comply with sub. (7), where applicable, and s. Ins 3.27 (5) (1), Wis. Adm. Code.

(9) "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 must 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), Wis. Adm. Code. Except in the case of direct response insurance, written acknowledgement of receipt of this pamphlet shall be obtained by the insurer. This pamphlet prepared by the office of the commissioner of insurance provides information on Medicare and advice to senior citizens on the purchase of Medicare supplement insurance and other health insurance. Insurers may obtain copies from the commissioner at cost or may reproduce this pamphlet themselves. This pamphlet shall 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

received notice that the revised pamphlet is available at the commissioner's office.

(10) APPROVAL NOT A RECOMMENDATION. While the commissioner may authorize the use of a particular designation on a policy or certificate in accordance with this section, that authorization is not to be construed or advertised as a recommendation of any particular policy or certificate by the commisisoner or the state of Wisconin.

(11) EXEMPTION OF CERTAIN POLICIES AND CERTIFICATES FROM CERTAIN STATUTORY MEDICARE SUPPLEMENT REQUIREMENTS. Policies and certificates described in sub. (2) (d) of this section, even if they are Medicare supplement policies as defined in s. 600.03 (35) (e), Stats., shall not be subject to:

(a) The special right of return provision for Medicare supplement policies set forth in s. 632.73 (2m), Stats., and s. Ins 3.13 (2) (j) 3., Wis. Adm. Code; and

(b) The special pre-existing diseases provision for Medicare supplement policies set forth in s. 632.76 (2) (b), Stats.

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

(13) EFFECTIVE DATE. This section was originally adopted in 1977 and was amended in 1978 and 1981. The requirements contained in or applications of the earlier versions which were not subsequently repealed continue to apply. The requirements or applications included in this revision apply to policies issued on or after July 1, 1982, except that

the requirements or applications included in subs. (8) and (11) of this section apply to policies issued or renewed on or after July 1, 1982.

APPENDIX

(COMPANY NAME)

OUTLINE OF MEDICARE

SUPPLEMENT COVERAGE

(The designation and caption required by sub. (4) (c) 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. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Medicare Supplement Coverage -- Policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to any deductibles and co-payment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the policy. 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 (delete if such coverage is provided).

(3) (a) (for intermediaries:)

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

(b) (for direct responses:)

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

(4) (A brief summary of the major benefit gaps in Medicare Parts A & B with a parallel description of supplemental benefits, including dollar amounts, provided by the Medicare supplement coverage in the following order:)

| SERVICE | BENEFIT | MEDICARE PAYS | THIS POLICY PAYS | YOU PAY |
|---|---|---|---|---|
| HOSPITALIZATION... semiprivate room and board, general nursing and miscellaneous hospital services and supplies | First 60 days | All but $(260) | | |
| | 61st to 90th day | All but $(65) a day | | |
| Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services | 91st to 150th day | All but $(130) a day | | |
| | Beyond 150 days | Nothing | | |
| POSTHOSPITAL SKILLED NURSING CARE... In a facility approved by Medicare, you must have been in a hospital for at least three days and enter the facility within 30 days after hospital discharge. | First 20 days | 100% of costs | | |
| | Additional 80 days | All but $(32.50) a day | | |
| | Beyond 100 days | Nothing | | |
| MEDICAL EXPENSE | Physician's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy and ambulance. | 80% of reasonable charge [after $(75) deductible] | | |

(5) (Statement that the policy does or does not cover the following:)

(a) Private duty nursing,

(b) Skilled nursing home care costs (beyond what is covered by Medicare),

(c) Custodial nursing home care costs,

(d) Intermediate nursing home care costs,

(e) Home health care above number of visits covered by Medicare,

(f) Physician charges (above Medicare's reasonable charge),

(g) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay),

(h) Care received outside of U.S.A.,

(i) Dental care of dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids.

(6) (A description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay, or in any other manner operate to qualify payments of the benefits described in (4) above, including conspicuous statements:)

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

(b) (That the 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) (The amount of premium for this policy.)

Drafting Note: The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate. The outline is subject to s. Ins 3.27 (5) (1) and s. Ins 3.27 (9) (u), (v) and (zh) 2. and 4., Wis. Adm. Code.

SECTION 7. S. Ins 3.46 (3) (c) is created to read:

Ins 3.46 (3) (c) This section applies to any individual insurance policy issued on or after July 1, 1982 to a person eligible for Medicare by reason of age which provides coverage for confinement or care in a nursing home in addition to providing hospital confinement indemnity coverage as defined in s. Ins 3.27 (4) (b) 6, Wis. Adm. Code.

The rule changes in this order shall take effect July 1, 1982.

Dated at Madison, Wisconsin, this 21 day of May 1981.

Thomas R. Hefty
Deputy Commissioner of Insurance

7113B