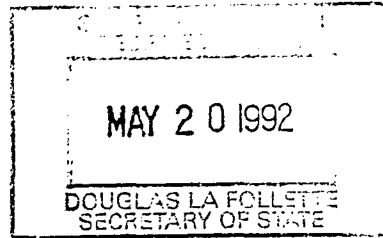
CR 91-142

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Robert D. Haase
Commissioner

121 East Wilson Street
P.O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-3585



MAY 20 1992
DOUGLAS LA FOLLETTE
SECRETARY OF STATE

RECEIVED
MAY 20 1992
2:50p
Revisor of Statutes
Bureau

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

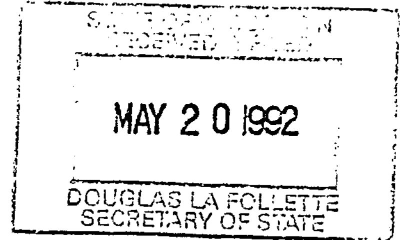
I, Robert D. Haase, Commissioner of Insurance and custodian of the official records of this Office, certify that the attached rule-making order affecting sections Ins 3.13 and 3.39, Wis. Adm. Code relating to the sale of Medicare Supplement insurance in the State of Wisconsin, was issued by this Office on May 19, 1992.

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 May 19, 1992.

Robert D. Haase
Commissioner of Insurance

8-1-92



RECEIVED

MAY 20 1992

Revisor of Statutes
Bureau

ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

REPEALING, RENUMBERING, AMENDING, REPEALING

AND RECREATING, AND CREATING A RULE

a. To repeal Ins 3.39 (3) (ai); 3.39 (3) (bl); 3.39 (3) (gl), (gm) and (il); 3.39 (4) (f); 3.39 (17), (18), (19) and (20); 3.39 (22) (c); 3.39 (24) (d); 3.39 Appendix 1 (2) (a);

b. To renumber Ins 3.13 (2) (jm); 3.39(5) (i) 6.;

c. To amend Ins 3.13 (2) (j) (intro.); 3.39 (1) (a); 3.39 (2) (intro.) and (a) 3.; 3.39 (3) (ag) and (ah); 3.39 (3) (im); 3.39 (4) (intro.); 3.39 (4) (a) 1., 3., 5., 10. and 14.; 3.39 (4) (b) 4., 5. and 7. and (c) 3.; 3.39 (4) (e); 3.39 (4) (g) 2.; 3.39 (4m); 3.39 (5) (i) (intro.), 5. and 7.; 3.39 (6) (intro.); 3.39 (8) (a) (intro.), (a) 1. and (c); 3.39 (11); 3.39 (16); 3.39 (22) (a) to (f); 3.39 (23) (a); 3.39 (23) (c) and (d); 3.39 (26) (b); 3.39 (27); 3.39 Appendix 1 (4), (6) and (11); 3.39 Appendix 4; 3.39 Appendix 5;

d. To repeal and recreate Ins 3.39 (14) (c); 3.39 (29); 3.39 Appendix 1 (1); 3.39 Appendix 6; and

e. To create Ins 3.39 (2) (a) 5.; 3.39 (3) (aj) and (al); 3.39 (3) (bm); 3.39 (3) (ij) and (ik); 3.39 (4) (a) 16., 17. and 18.; 3.39 (4) (h); 3.39 (5) (j); 3.39 (14) (d), (e), (f), (g), (h), (i) and (j); 3.39 (23) (bl); 3.39 (24) (g); 3.39 (30), (31), (32) and (33); 3.39 Appendix 7 relating to the sale of Medicare supplement insurance in the state of Wisconsin.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

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

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

This proposed rule amends the existing rule establishing minimum standards for Medicare supplement policies sold in Wisconsin to conform the current rule with the newly revised model requirements of the National Association of Insurance Commissioners (NAIC), which must be met in order for a state to be certified under federal law to regulate Medicare supplement policies. (The recent NAIC model was adopted July 30, 1991.) Most of the changes in this proposed rule incorporate verbatim NAIC language into the Wisconsin rule so that compliance with the requirements of federal law is clearly established.

The substantive changes included in this proposed rule are:

Sections 1 and 2. Clearly shows that Medicare supplement policies are not subject to this provision of s. Ins 3.13 and moves the substantive requirements for the notice of the right to return for Medicare replacement policies from s. Ins 3.13 to s. Ins 3.39 (7) (d) where other requirements for these policies are contained.

Sections 3 to 13. Technical changes to conform Wisconsin's definitions to the current changes made in the NAIC model Medicare supplement rule. A number of the definitions have been deleted and moved to s. Ins 3.39 (4) (a) indicating that those definitions in the policies cannot be worded less favorably than as defined by Medicare.

Section 14. Revises the rule to conform with NAIC model requirements regarding preexisting condition limitations and the insured's right to "suspend" the policy if they become entitled to medical assistance.

Section 15. Requires the outline of coverage to be printed in no less than 12 point type and deletes references to currently nonexistent sections.

Section 16. Clarifies the loss ratio information which must be submitted with the policy form.

Sections 17 and 18. Technical corrections.

Section 19. Clarifies that existing policies need only conform to the standards in effect at the time of issuance.

Section 20. Amends the requirement for issuing coverage during an open enrollment period to include riders which are offered by the insurer.

Section 21. Conforms the Wisconsin foreign travel rider to the NAIC model foreign travel benefit and changes the drug rider to allow a cap of at least $3,000.

Sections 22 and 24. Technical corrections.

Section 25. Requires that the pamphlet "Health Insurance Advice for Senior Citizens" be in a type size no smaller than 12 point type.

Section 26. Repeals previous language and creates the current model language requiring insurers to comply with the federal law (Omnibus Budget Reconciliation Act "OBRA") regarding claims procedures with Medicare.

Section 27. Deals with the rating structures and how policy form discontinuance, reinsurance, and other factors should be considered in calculating loss ratios and other information. In addition, a requirement is added that for applicants over age 75, insurers must medically underwrite the application. (This is the same requirement as currently contained in s. Ins 3.46 (10) regarding long-term care.)

Section 28. Amends and clarifies how rates and loss ratios must be calculated in order to comply with federal law and the NAIC model.

Section 29. Requires a statement on the first page of the policy regarding rate changes or automatic premium increases based on age in addition to other technical changes.

Section 30. Repeals four sections which were transition requirements whose dates of usage have expired.

Section 31. Amends the statements and questions which must be contained on any application for a Medicare supplement policy to those required by the NAIC model and federal law.

Section 32. Requires the direct response insurer to return a copy of the application to the insured upon delivery of the policy.

Section 33. Requires that the notice regarding replacement be in a type size not less than 10 point and combines the replacement notice for policies sold by direct response insurers and policies sold by agents into a single form.

Sections 34 to 38. Technical corrections based on the NAIC model.

Section 39. Creates four new sections. The first deals with the requirements for Medicare Select policies and certificates. Wisconsin has been chosen as one of the 15 Medicare Select demonstration states. This section will govern the issuance and regulation of those policies. Section 34 details how an insurer must report information regarding loss ratios and calculate the refund. This is required by federal law and the NAIC model. Ins 3.39 (32) was created to comply with the NAIC model and allows the Commissioner to hold public hearings to gather information. This power exists elsewhere in the statutes and is merely restated here. The next section deals with how certain state mandated benefits shall be interpreted on the renewal of policies issued prior to the effective date of this rule.

Section 40 to 42. Amends Appendix 1 (the outline of coverage) so that the descriptions and information conform to federal law and the NAIC model. In addition, the chart contained in the outline of coverage is amended to show that the rider cannot be included in the base policy, but must be optional and available separately.

Section 43. Amends Appendix 4 to clarify how companies are to inform their insureds of changes in Medicare. These are technical corrections.

Section 44. Amends Appendix 5 so that the notice regarding replacement will conform to the NAIC model requirements.

Sections 45 and 46. Contain the NAIC model reporting form to calculate refunds and for reporting multiple Medicare supplement policies.

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

Ins 3.13 (2) (j) Except as provided in ~~par. (jm)~~ s. Ins 3.39 (7) (d), the provision or notice regarding the right to return the policy required by s. 632.73, Stats., shall:

SECTION 2. Ins 3.13 (2) (jm) is renumbered Ins 3.39 (7) (d).

SECTION 3. Ins 3.39 (1) (a), (2) (intro.) and (2) (a) 3. are amended to read:

Ins 3.39 STANDARDS FOR DISABILITY INSURANCE SOLD TO THE MEDICARE ELIGIBLE. (1) PURPOSE. (a) This section establishes requirements for health insurance policies sold to Medicare eligible persons ~~as required by the Medicare Catastrophic Act of 1988~~. Disclosure provisions are required 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.

(2) SCOPE. This section applies to individual and group disability policies ~~sold~~ sold, delivered or issued for delivery in Wisconsin to medicare eligible persons as follows:

(2) (a) 3. Any individual or group policy sold in Wisconsin predominantly ~~in-Wisconsin-to-the-medicare-eligible-by-reason-of-age~~ to individuals or groups of individuals who are 65 years of age or older 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

SECTION 4. Ins 3.39 (3) (ag) and (ah) are amended to read:

Ins 3.39 (3) (ag) "Applicant" means:

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

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

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

SECTION 5. Ins 3.39 (3) (ai) is repealed.

SECTION 6. Ins 3.39 (2) (a) 5., (3) (aj) and (al) are created to read:

Ins 3.39 (2) (a) 5. Any individual or group policy or certificate sold in Wisconsin to persons under 65 years of age and eligible for medicare by reason of disability which offers hospital, medical, surgical or other disability coverage, except for a policy or certificate which offers solely nursing home, hospital confinement indemnity or specified disease coverage.

(3) (aj) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(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. 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 7. Ins 3.39 (3) (bl) is repealed.

SECTION 8. Ins 3.39 (3) (bm) is created to read:

Ins 3.39 (3) (bm) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

SECTION 9. Ins 3.39 (3) (gl), (gm) and (il) are repealed.

SECTION 10. Ins 3.39 (3) (ij) and (ik) are created to read:

Ins 3.39 (3) (ij) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(ik) "Replacement" means any transaction wherein new Medicare supplement insurance is to be purchased, and it is known to the agent or company at the time of application that, as part of the transaction, existing accident and sickness insurance has been or is to be lapsed, cancelled or terminated or the benefits thereof substantially reduced.

SECTION 11. Ins 3.39 (3) (im) is amended to read:

Ins 3.39 (3) (im) 1. "Sickness" shall not be defined to be more restrictive than ~~sickness~~ <u>illness</u> or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.

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

SECTION 12. Ins 3.39 (4) (intro.) is amended to read:

Ins 3.39 (4) MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY AND CERTIFICATE REQUIREMENTS. Except as explicitly allowed by subs. (6)<u>,</u> ~~and~~ (7) <u>and (30)</u>, no disability insurance policy or certificate shall relate its coverage to Medicare or be structured, advertised, or marketed as a Medicare supplement or as a Medicare replacement policy unless:

SECTION 13. Ins 3.39 (4) (a) 1., 3., 5., 10. and 14. are amended to read:

Ins 3.39 (4) (a) 1. Provides only the coverage set out in sub. (5)<u>,</u> ~~or~~ (7) <u>or (30)</u> and applicable statutes and contains no exclusions or limitations other than those permitted by sub. (8). <u>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 may issue an HMO Medicare supplement policy under sub. (5) and all HMO Medicare supplement policies must be written in accordance with sub. (30).</u>

3. Contains no definitions of terms such as "Medicare eligible expenses," "accident," "sickness," "mental or nervous disorders," "skilled nursing facility," "hospital," "nurse," "physician," "Medicare approved

expenses," "benefit period," "convalescent nursing home," or "outpatient prescription drugs" which are worded less favorably to the insured person than the corresponding Medicare definition or the definitions contained in sub. (3), and defines "Medicare" as in accordance with sub. (3) (c);"

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 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 if the insured moves out of the service area;

10. Contains on the first page the designation, printed in 18-point type, and in close conjunction the caption printed in 12-point type, prescribed in sub. (5), ~~or~~ (7) or (30);

14. Contains no exclusion, limitation, or reduction of coverage for a specifically name or described condition ~~for-longer-than-6-months~~ after the policy effective date.

SECTION 14. Ins 3.39 (4) (a) 16., 17. and 18. are created to read:

Ins 3.39 (4) (a) 16. Except for permitted preexisting condition clauses as described in subd. 14, 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.

17. No Medicare supplement policy or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

18. a. 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 certificateholder for the period not to exceed 24 months in which the policyholder or certificateholder 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 certificateholder 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 shall return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

b. If the suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of the entitlement) as of the termination of the entitlement if the policyholder or certificateholder provides notice of loss of the entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of the entitlement.

c. Reinstitution of such coverages:

i. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

ii. Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

iii. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

SECTION 15. Ins 3.39 (4) (b) 4., 5., and 7. and (c) 3. are amended to read:

Ins 3.39 (4) (b) 4. Contains in close conjunction on its first page the designation, printed in a distinctly contrasting color in 24-point type, and the caption, printed in a distinctly contrasting color in 18-point type prescribed in sub. (5), ~~or~~ (7) or (30);

5. Is substantially in the format prescribed in Appendix 1 to this section for the appropriate category and printed in no less than 12-point type;

7. Contains a listing of the required coverage as set out in sub. (5) (c), (e) and (g), and the optional coverages as set out in sub. (5) ~~(d), (f), (h) and~~ (i), and the annual premiums therefor, substantially in the format of sub. (11) of Appendix 1; and

(c) 3. Shall only provide coverage as defined in sub. (5) ~~(d), (f), (h) or~~ (i) or provide coverage to meet statutory mandated provisions.

SECTION 16. Ins 3.39 (4) (e) is amended to read:

Ins 3.39 (4) (e) The anticipated loss ratio for any new policy form, that is, the expected percentage of the aggregate amount of premiums ~~collected~~ earned which will be returned to insureds in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form:

1. Is computed on the basis of anticipated incurred claims or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the entire period for which the policy form provides coverage, in accordance with accepted actuarial principles and practices;

2. ~~Complies~~ Is submitted to the commissioner along with the policy form and is accompanied by rates and an actuarial demonstration that expected claims in relationship to premiums comply with the loss ratio standards in

sub. (16) (d)~~;~~. The policy form will not be approved unless the anticipated loss ratio along with the rates and actuarial demonstration show compliance.

~~3. Is submitted to the commissioner along with the policy form.~~

SECTION 17. Ins 3.39 (4) (f) is repealed.

SECTION 18. Ins 3.39 (4) (g) 2. is amended to read:

Ins 3.39 (4) (g) 2. Includes in its filing an actuarially sound demonstration that the rate change will not result in a loss ratio over the life of the policy which would violate sub. ~~(4) (e)~~ (16) (d).

SECTION 19. Ins 3.39 (4) (h) is created to read:

Ins 3.39 (4) (h) All Medicare supplement policies written prior to January 1, 1992, shall comply with the standards then in effect and shall comply with par. (14) (c).

SECTION 20. Ins 3.39 (4m) is amended to read:

Ins 3.39 (4m) OPEN ENROLLMENT. (a) Unless the coverage is subject to sub. (7), an insurer may not deny or condition the issuance or effectiveness of, or discriminate in the pricing of, basic Medicare supplement coverage, 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 years of age or older first enrolled for benefits under Medicare Part B on any of the following grounds:

~~(a)~~ 1. Health status.

~~(b)~~ 2. Claims experience.

~~(c)~~ 3. Receipt of health care.

~~(d)~~ 4. Medical condition.

(b) This section shall not prevent the application of any preexisting condition limitation which is in compliance with sub. 4 (a) 2.

SECTION 21. Ins 3.39 (5) (i) (intro.), 5. and 7. are amended to read:

Ins 3.39 (5) (i) Permissible additional coverage ~~which-may-be~~ added only if coverage is to the policy as separate riders or amendments. The insurer shall issue a separate rider for each coverage the insurer chooses to offer and each rider shall be priced separately and available for purchase separately~~.~~ and may consist only of the following:

5. "Coverage for benefits obtained outside the United States." An insurer which offers this benefit shall not limit coverage to Medicare deductibles and copayments. Coverage may contain a deductible of up to $250. Coverage shall pay at least 80% of ~~reasonable-charges.--The-benefit-period shall-be-at-least-30-days-per-year.~~ 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.

7. At least ~~75%~~ 50% of the ~~usual-and-customary~~ charges for outpatient prescription drugs after a deductible of no greater than ~~$100~~ $250 per year to a maximum of at least $3,000 in benefits received by the insured per year. The rider shall be designated as: OUTPATIENT PRESCRIPTION DRUG ~~USUAL-AND CUSTOMARY-CHARGES~~ RIDER.

SECTION 22. Ins 3.39 (5) (i) 6. is renumbered to 3.39 (5) (c) 14.

SECTION 23. Ins 3.39 (5) (j) is created to read:

Ins 3.39 (5) (j) For HMO Medicare Select policies, only the benefits specified in sub. (30) (p) and (q), in addition to Medicare benefits.

SECTION 24. Ins 3.39 (6) (intro.), (8) (a) (intro.), (a) 1. and (c) are amended to read:

Ins 3.39 (6) (intro.) USUAL, CUSTOMARY AND REASONABLE CHARGES. ~~If an insurer includes~~ An issuer can only include a policy provision limiting benefits to the usual, customary and reasonable charge as determined by the ~~insurer,~~ issuer for coverages described in subds. (5) (c) 8. and 13. If the issuer includes such a provision, the ~~insurer~~ issuer shall:

(8) PERMISSIBLE MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY OR CERTIFICATE EXCLUSIONS AND LIMITATIONS. (a) The coverage set out in subs. (5) ~~and~~ , (7) and (30);

1. ~~May~~ Shall exclude expenses for which the insured is compensated by Medicare;

(c) The coverages set out in subs. (5) ~~and~~ , (7) and (30) may not exclude, limit, or reduce coverage for specifically named or described pre-existing diseases or physical conditions, except as provided in par. (a) 3.

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 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. This pamphlet provides information on Medicare and advice to senior citizens

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

SECTION 26. Ins 3.39 (14) (c) is repealed and recreated to read:

Ins 3.39 (14) (c) An issuer shall comply with section 1882 (c) (3) of the Social Security Act, as enacted by section 4081 (b) (2) (C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203, by:

1. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

2. Notifying the participating physician or supplier and the beneficiary of the payment determination;

3. Paying the participating physician or supplier directly;

4. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

5. Paying user fees for claim notices that are transmitted electronically or otherwise;

6. Providing to the U.S. secretary of health and human services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers; and

7. Certifying compliance with the requirements set forth in this subsection on the Medicare supplement insurance experience reporting form.

SECTION 27. Ins 3.39 (14) (d), (e), (f), (g), (h), (i) and (j) are created to read:

Ins 3.39 (14) (d). Except as provided in sub. (1), an issuer shall continue to make available for purchase any policy form or certificate form issued after [the effective date of this rule: revisor to insert date] that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

1. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

2. An issuer that discontinues the availability of a policy form or certificate form pursuant to subd. 1., shall not file for approval a new policy form or certificate form of the same type as the discontinued form for a period of 5 years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

3. This subsection shall not apply to the riders permitted in subs. (5) (j).

(e) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(f) A change in the rating structure or methodology shall be considered a discontinuance under par. (d) 1. unless the issuer complies with the following requirements:

1. The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

2. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

(g) Except as provided in par. (h) the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in sub. (31).

(h) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(i) No insurer 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 prior to issuing coverage, the insurer 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 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 (16) is amended to read:

Ins 3.39 (16) (title) LOSS RATIO REQUIREMENTS AND RATES FOR EXISTING POLICIES. (a) Every ~~insurer~~ issuer providing Medicare supplement ~~policies~~ coverage on a group or individual basis on policies or certificates issued before or after the [effective date of this section: revisor to insert date] in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis to earned premiums by ~~number-of-years of~~ policy duration~~-demonstrating-that-it-is-in-compliance-with-the-applicable loss-ratio-standards-contained-in-par.-(d)-and-that-the-period-for-which-the policy-is-rated-is-reasonable-in-accordance-with-accepted-actuarial-principles and-experiences~~ for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of par. (d) when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

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

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

~~2.-The-expected-losses-in-relation-to-premiums-over-the-entire-period for-which-the-policy-is-rated-comply-with-the-requirements-of-par.-(d).--An expected-3rd-year-loss-ratio-which-is-greater-than-or-equal-to-the-applicable percentage-shall-be-demonstrated-for-policies-or-certificates-in-force-less than-3-years.~~ The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected 3rd year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than 3 years.

(c) As soon as practicable, but no later than October 1 of the year prior to the effective date of ~~Medicare-benefit-changes,~~ enhancements in Medicare benefits, every insurer providing Medicare supplement ~~insurance contracts~~ policies or certificates in this state shall file with the commissioner in accordance with the applicable filing procedures of this state~~:~~ ~~1.-a.~~ ~~Appropriate~~ appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the current premium for the applicable policies or ~~contracts~~ certificates. Supporting documents as necessary to justify the adjustment shall accompany the filing.

~~b.~~1. Every insurer ~~providing-Medicare-supplement-insurance-or benefits-to-a-resident-of-this-state~~ shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or ~~contract~~ 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 for such Medicare supplement insurance policies or ~~contracts~~ 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. ~~Premiums-adjustments-shall-be-in-the-form of-refunds-or-premium-credits-and-shall-be-made-no-later-than-upon-renewal-if a-credit-is-given,-or-within-60-days-of-the-renewal-date-or-anniversary-date if-a-refund-is-provided-to-the-premium-payer.--Premium-adjustments-shall-be calculated-for-the-period-commencing-with-Medicare-benefit-changes.~~

~~3.~~ 2. If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this subsection.

~~2.--Any~~ 3. An issuer shall file any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement ~~insurance~~ policy or certificate modifications necessary to eliminate benefit duplications with Medicare. ~~Any~~ Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or ~~contract~~ certificate.

(d) For purposes of sub. (4) (e) and this ~~par.-(b)~~ subsection, the loss ratio standards shall be:

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

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

and, for existing policies subject to this subsection, the loss ratio shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

(e) An issuer may not use or change any premium rates for an individual or group Medicare supplement policy or certificate unless the

rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner and in accordance with sub. (4) (g).

SECTION 29. Ins 3.39 (22) (a) to (f) are amended to read:

Ins 3.39 (22) REQUIRED DISCLOSURE PROVISIONS. (a) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision must be consistent with the type of contract issued. Such provision shall be appropriately captioned and shall appear on the first page of the policy. and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(b) Except for riders or endorsements by which the insurer 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 ~~must~~ 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.

(c) A Medicare supplement policy or certificate which provides for the payment of certain benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall

include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(d) If a Medicare supplement policy or certificate contains any limitations with respect to pre-existing conditions, such limitations ~~must~~ shall appear on the first page.

(e) Medicare supplement policies ~~or~~ and certificates shall have a notice prominently printed on the first page of the policy ~~or~~ and certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(f) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, ~~every-insurer,-health care-service-plan-or-other-entity-providing-Medicare-supplement-insurance-or benefits-to-a-resident-of-this-state~~ an issuer shall notify its policyholders, contractholders and certificateholders of modifications it has made to Medicare supplement insurance policies or ~~contracts~~ certificates in the format similar to Appendix 4. The notice shall:

1. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement ~~insurance~~ policy or ~~contract~~ certificate, and

2. Inform each ~~covered-person~~ policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

SECTION 30. Ins 3.39 (17), (18), (19), (20) and (22) (c) are repealed.

SECTION 31. Ins 3.39 (23) (a) is amended to read:

Ins 3.39 (23) REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE. (a) Application forms for Medicare supplement coverage shall comply with all relevant statutes and rules. The application form, or a supplementary form signed by the applicant and agent, shall include the following statements and questions:

[Statements]

1. You do not need more than one Medicare supplement policy.

2. If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

3. The benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

4. Counseling services are available to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid. See the booklet "Health Insurance Advice for Senior Citizens" which you received at the time you were solicited to purchase this policy.

[Questions]

To the best of your knowledge:

5. Do you have another Medicare supplement ~~insurance~~ policy or certificate in force (including health care service contract, health maintenance organization contract)?

If so, with which company?

~~(2)-Did-you-have-another-Medicare-supplement-policy-or-certificate-in force-during-the-last-twelve-(12)-months?~~

~~(a)-If-so,-with-which-company?~~

~~(b) If that policy lapsed, when did it lapse?~~

6. Do you have any other health insurance policies that provide benefits which this Medicare supplement policy would duplicate?

a. If so, with which company?

b. What kind of policy?

~~(4) Do~~ 7. If the answer to question 5 or 6 is yes, do you intend to replace ~~any of your~~ these medical or health ~~insurance coverage~~ policies with this policy [certificate]?

~~(3)~~ 8. Are you covered by Medicaid?

SECTION 32. Ins 3.39 (23) (bl) is created to read:

Ins 3.39 (23) (bl) 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, shall be returned to the applicant by the insurer upon delivery of the policy.

SECTION 33. Ins 3.39 (23) (c) and (d) are amended to read:

Ins 3.39 (23) (c) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage 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. A direct response insurer 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~~, other than a direct response insurer,~~ shall be provided in substantially the form as shown

in Appendix 5. ~~Direct-response-insurers-shall-use-a-notice-in-substantially the-form-as-shown-in-Appendix-6.~~

SECTION 34. Ins 3.39 (24) (d) is repealed.

SECTION 35. Ins 3.39 (24) (g) is created to read:

Ins 3.39 (24) (g) The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this section.

SECTION 36. Ins 3.39 (26) (b) is amended to read:

Ins 3.39 (26) (b) The items in par. (a) must be grouped by individual policyholder and listed on a form in substantially the same format as Appendix 7 on or before March 1 of each year.

SECTION 37. 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 shall waive any time periods applicable to pre-existing condition waiting periods in the new Medicare supplement policy ~~for-similar-benefits~~ to the extent time was satisfied under the original policy or certificate.

SECTION 38. Repeal and recreate Ins 3.39 (29) to read:

Ins 3.39 (29) FILING AND APPROVAL REQUIREMENTS. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

SECTION 39. Ins 3.39 (30) to (33) are created to read:

Ins 3.39 (30) MEDICARE SELECT POLICIES AND CERTIFICATES. (a) 1. This subsection shall apply to Medicare Select policies and certificates.

2. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(b) For the purposes of this section:

1. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

2. "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices or provision of services concerning a Medicare Select issuer or its network providers.

3. "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

4. "Medicare Select policy" or "Medicare Select certificate" mean, respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

5. "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

6. "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

7. "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

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

(d) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner.

(e) A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

1. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

a. Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual medical travel times within the community.

b. The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either to deliver adequately all services that are subject to a restricted network provision or to make appropriate referrals.

c. There are written agreements with network providers describing specific responsibilities.

d. Emergency care is available 24 hours per day and 7 days per week.

e. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

2. A statement or map providing a clear description of the service area.

3. A description of the grievance procedure to be utilized.

4. A description of the quality assurance program, including:

a. The formal organizational structure;

b. The written criteria for selection, retention and removal of network providers; and

c. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

5. A list and description, by specialty, of the network providers.

6. Copies of the written information proposed to be used by the issuer to comply with par. (i).

7. Any other information requested by the commissioner.

(f) 1. A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing such changes. Such changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

2. An updated list of network providers shall be filed with the commissioner at least quarterly.

(g) A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

1. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

2. It is not reasonable to obtain such services through a network provider.

(h) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(i) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

1. An outline of coverage 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.

2. A description, including address, phone number and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

3. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.

4. A description of coverage for emergency and urgently needed care and other out of service area coverage.

5. A description of limitations on referrals to restricted network providers and to other providers.

6. A description of the policyholder's or certificateholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

7. A description of the Medicare Select issuer's quality assurance program and grievance procedure.

8. A designation: MEDICARE SELECT POLICY. This designation shall be immediately below and in the same type size as the designation required in sub. (5) a. or (7) (b) 1.

(j) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to par. (i) of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

(k) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from its subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

1. The grievance procedure shall be described in the policy and certificate and in the outline of coverage.

2. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

3. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

4. If a grievance is found to be valid, corrective action shall be taken promptly.

5. All concerned parties shall be notified about the results of a grievance.

6. The issuer shall report no later than each March 31st to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of

grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

(l) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(m) 1. At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for 6 months.

2. For the purposes of subd. 1., a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(n) Medicare Select policies and certificates shall provide for continuation of coverage in the event the U.S. secretary of health and human services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or its substantial amendment.

1. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

2. For the purposes of subd. 1., a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(o) A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States department of health and human services, for the purpose of evaluating the Medicare Select Program.

(p) A Medicare Select policy shall contain the following benefits:

1. The "basic Medicare supplement coverage" as described in section (5) (c).

2. Coverage for the Medicare Part A hospital deductible as described in par. (5) (i) 1.

3. Coverage for home health care for an aggregate of 365 visits per policy year as described in par. (5) (i) 2.

4. Coverage for the Medicare Part B medical deductible as described in par. (5) (i) 3.

5. Coverage for the difference between Medicare Part B eligible charges and the actual charges for authorized referral services. This coverage shall not be described with words or terms that would lead insureds to believe the coverage is for Medicare part B Excess Charges as described in par. (5) (i) 4.

6. Coverage for benefits obtained outside of the United States as described in par. (5) (i) 5.

7. Coverage for preventive health care services as described in sec. (5) (i) 6.

(q) A Medicare Select policy may include permissible additional coverage as described in par. (5) (i) 7. This rider, if offered, shall be added to the policy as a separate rider or amendment, shall be priced separately and available for purchase separately.

(31) REFUND OR CREDIT CALCULATION. (a) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the reporting form contained in Appendix 6 for each type of policy form as described in sub. (14).

(b) If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type of policy form as described in sub. (14). For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(c) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds $5.00. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by

the secretary of health and human services, but in no event shall it be less than the average rate of interest for 13-week U.S. treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(32) PUBLIC HEARINGS. The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this section if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the commissioner.

(33) ADDITIONAL BENEFITS FOR POLICIES RENEWED. On the renewal of any Medicare supplement policy the benefits required in sub. (5) (c) 8 and 13 and sub. (7) (b) 3. h and i shall be provided.

SECTION 40. Ins 3.39 Appendix 1 (1) is repealed and recreated to read:

Ins 3.39 Appendix 1

(1) **PREMIUM INFORMATION**

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY <u>VERY</u> CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to (insert issuer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments directly to you.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

SECTION 41. Ins 3.39 Appendix 1 (2) (a) is repealed.

SECTION 42. Ins 3.39 Appendix (4), (6) and (11) are amended to read:

Ins 3.39 (4) (a) For medicare supplement policies, provide a brief summary of the major benefits and gaps in Medicare Parts A & B with a parallel description of supplemental benefits, including dollar amounts, as outlined in these charts.

(b) For medicare replacement policies, provide a brief summary of both the basic Medicare benefits in the policy and additional benefits using the basic format as outlined in these charts and modified to accurately reflect the benefits.

(c) If the coverage is provided by a health maintenance organization as defined in s. 609.01 (2), Stats., provide a brief summary of the coverage for emergency care anywhere and urgent care received outside the service area if this care is treated differently than other covered benefits.

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

MEDICARE PART A BENEFITS	PER BENEFIT PERIOD	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
Hospitalization. Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services.	First 60 days	All but $(current deductible)	$0 ~~or~~ ~~($---)~~ __ or /_/ OPTIONAL PART A DEDUCTIBLE RIDER*	
	61st to 90th days	All but $(current amount per day)	$(current amount per day)	
	91st to 150th days	All but $(current amount per day)	$(current amount per day)	
	Beyond 150 days	Nothing	All	
Skilled nursing care in a facility approved by Medicare. Confinement must meet Medicare standards. You must have been in a hospital for at least three days and enter the facility within 30 days after discharge.	First 20 days	100% of costs	$0	
	Additional 80 days	All but $(current amount per day)	$(current amount per day)	
Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 additional days per lifetime	

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

701R36
05/14/92

MEDICARE PART A BENEFITS	PER BENEFIT PERIOD	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
Blood		All but 1st 3 pints	First 3 pints	
Home health care		100% of charges for visits considered medically necessary by Medicare	40 visits ~~or~~ ~~365 visits~~ __ or /_/ OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER*	

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

MEDICARE SUPPLEMENT POLICIES--PART B BENEFITS

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
Medical expenses. Eligible expenses for physician's services, 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 charge	20% of Medicare app-roved charge ~~or~~ ~~The difference between what Medicare pays and the excess charge~~ __ or /_/ OPTIONAL MEDICARE PART B EXCESS CHARGES RIDER*	
Outpatient prescription drugs		$0	$0 ~~or~~ ~~75% of out-patient pre-scription drugs with a deductible of $------ (not more than $100)~~ __ or /_/ OPTIONAL OUTPATIENT PRESCRIPTION DRUG ~~USUAL-AND-CUSTOMARY CHARGES~~ RIDER*	
Blood		80% of costs except non-replacement fees (blood deductible) for first 3 pints (after $_____ deductible/ calendar year)	20% of all costs and the first 3 pints in each calendar year	

<u>Immunosuppressive drugs</u>	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.

(6) CONSPICUOUS STATEMENTS AS FOLLOWS:

~~(a)--That-the-chart-summarizing-Medicare-benefits-only-briefly describes-such-benefits.~~ This ~~chart~~ outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult 'The Medicare Handbook' for more details.

~~(b)--That-the-Health-Care-Financing-Administration-or-its-Medicare publications-should-be-consulted-for-further-details-and-limitations.~~

(11) The premium for the policy and riders, if any, in the following format:

MEDICARE SUPPLEMENT PREMIUM INFORMATION

Annual Premium

$(   )   BASIC MEDICARE SUPPLEMENT ~~POLICY~~ COVERAGE

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT POLICY

Each of these riders may be purchased separately.

(Note: Only optional coverages provided by rider shall be listed here.

$(   )   1. Part A deductible
100% of Part A deductible

$(   )   2. Additional home health care
An aggregate of 365 visits per year including those covered by Medicare

$(   )   3. Part B deductible
100% of Part B deductible

$(   )   4. Part B excess charges
Difference between what Medicare pays and the amount charged by the provider which shall be no greater than the actual charge or the limiting charge allowed by Medicare, whichever is less

$(   )   5. ~~Usual-and-customary-outpatient~~ Outpatient prescription drug charges
~~75%~~ At least 50% of the ~~usual-and-customary~~ charges after a deductible of $_______ (no more than $~~100~~ $250) to a maximum benefit of $ _______ (no less than $3,000) per year

$(   )   6. Foreign travel rider

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

SECTION 43. Ins 3.39 Appendix 4 is amended to read:

Ins 3.39 Appendix 4

(COMPANY NAME)

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE - ~~1990~~ 19--

THE FOLLOWING CHART BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY!

[A BRIEF DESCRIPTION OF THE REVISIONS TO MEDICARE PARTS A & B WITH A PARALLEL DESCRIPTION OF SUPPLEMENTAL BENEFITS WITH SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS, PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE IN SUBSTANTIALLY THE FOLLOWING FORMAT.]

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In ~~1989~~ 19-- Medicare Pays Per Benefit Period	Effective January 1, ~~1990,~~ 19--, Medicare Will Pay	In ~~1989~~ 19-- Your Coverage Pays	Effective January 1, ~~1990,~~ 19--, Your Coverage Will Pay Per Calendar Year
MEDICARE PART A SERVICES AND SUPPLIES				
Inpatient Hospital Services	Unlimited number of hospital days after ~~$560~~ $-- deductible	All but ~~$592~~ $-- for first 60 days/benefit period		
Semi-Private Room & Board		All but ~~$148~~ $-- a day for 61st-90th days/ benefit period		

701R42
05/14/92

Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room		All but $296 $-- a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)
BLOOD	Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B	pays all costs except nonreplacement fees (blood deductible) for first 3 pints of each benefit period
~~SKILLED NURSING FACILITY CARE~~	~~There is no prior confinement requirement for this benefit~~	~~100% of costs for 1st 20 days (after a 3-day period hospital confinement)/ benefit period~~
	~~First 8 days --all but $25.50~~ $-- a day	~~All but $74.00~~ $-- ~~a day for 21st-100th days/benefit period~~
	~~9th through 150th day-- 100% of costs period~~	~~Beyond 100 days-- nothing/benefit~~
	~~Beyond 150 days---nothing~~	

SKILLED NURSING FACILITY CARE	Skilled nursing care in a facility approved by Medicare. Confinement must meet Medicare standards. You must have been in a hospital for at least three days and enter the facility within 30 days after discharge.	
	First 20 days 100% of costs	First 20 days 100% of costs
	Additional 80 days all but $(current amount per day)	Additional 80 days all but $(current amount per day)
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after ~~$75~~ $-- deductible calendar year)	80% of allowable charges (after ~~$75~~ $-- deductible/
PRESCRIPTION DRUGS	~~Inpatient~~ Outpatient prescription drugs. 80% of allowable charges for immuno-suppressive drugs during the first year following a covered transplant (after ~~$75~~ $-- deductible/ calendar year)	~~Inpatient~~ Outpatient prescription drugs. 80% of allowable charges for immuno-suppressive drugs during the first year following a covered transplant (after ~~$75~~ $-- deductible/ calendar year)

BLOOD	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after ~~$75~~ $-- deductible/ calendar year)	80% of costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after ~~$75~~ $-- deductible/ calendar year)

~~[Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage benefits, they should be shown.]~~

[Describe any coverage provisions changing due to Medicare modifications.]

[Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.]

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT POLICY CONTACT:

[COMPANY OR FOR AN INDIVIDUAL POLICY - NAME OF AGENT] [ADDRESS/PHONE NUMBER]

SECTION 44. Ins 3.39 Appendix 5 is amended to read:

Ins 3.39 Appendix 5

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to ~~lapse-or-otherwise~~ terminate existing Medicare supplement insurance or other health insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy ~~provides~~ will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. ~~For-your-own-information-and-protection,-you-should-be-aware-of-and seriously-consider-certain-factors-which-may-affect-the-insurance-protection available-to-you-under-the-new-policy.~~

You should review this new coverage carefully~~,-comparing~~ . Compare it with all accident and sickness coverage you now have~~,-and-terminate~~ . Terminate your present policy only if, after due consideration, you find that the purchase of this Medicare supplement coverage is a wise decision. Do not cancel your present policy until you have received your new policy and are sure you want to keep it.

STATEMENT TO APPLICANT BY ISSUER. AGENT [BROKER OR OTHER REPRESENTATIVE]: ~~(Use-additional-sheets,-as-necessary.)~~

I have reviewed your current medical or health insurance coverage. ~~I-believe the~~ The replacement of insurance involved in this transaction ~~materially improves-your-position~~ does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s):. ~~My-conclusion-has-taken-into-account-the-following considerations,-which-I-call-to-your-attention:~~

_____ Additional benefits.
_____ No change in benefits, but lower premiums.
_____ Fewer benefits and lower premiums.
_____ Other.
(please specify) ______________________________
____
____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods

applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the ~~original~~ Medicare supplement policy.

~~3. If you are replacing existing Medicare supplement insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.~~

~~4.~~3. If, ~~after due consideration,~~ you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, ~~reread~~ review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

____

(Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

~~The above "Notice to Applicant" was delivered to me on:~~

~~____________________~~

~~(Date)~~

____

(Applicant's Signature)

____

(Date)

*Signature not required for direct response sales.

(NOTE: Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.)

SECTION 45. Ins 3.39 Appendix 6 is repealed and created to read:

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)		
	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) 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

Worksheet

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES FOR CALENDAR YEAR ________

TYPE ______________________ SMSBP (p) ______________________

for the State of ______________________

Company Name ______________________

NAIC Group Code ____________ NAIC Company Code ______________________

Address ______________________

Person Completing This Exhibit ______________________

Title ______________________ Telephone Number ______________________

(a) Year	(a) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Reserve	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.4
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception: (l + n) / (k + m):

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2
(etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989; etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for information purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan. For Wisconsin reports, show the applicable policy form number.

Worksheet

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES FOR CALENDAR YEAR ________

TYPE ______________________ SMSBP (p) ______________________

for the State of ______________________

Company Name ______________________

NAIC Group Code __________ NAIC Company Code ______________________

Address ______________________

Person Completing This Exhibit ______________________

Title ______________________ Telephone Number ______________________

(a)	(a)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
Year	Earned Premium	Factor	(b) x (c)	Cumulative Loss Ratio	(d) x (e)	Factor	(b) x (g)	Cumulative Loss Reserve	(h) x (i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.8
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception: (l + n) / (k + m):

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2
(etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989; etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for information purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan. For Wisconsin reports, show the applicable policy form number.

701R52
05/14/92

SECTION 46. Ins 3.39 Appendix 7 is created to read:

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: ____________________

Address: ____________________

____

Phone Number: ____________________

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate Number	Date of Issuance

____
Signature

____
Name and Title (please type)

____
Date

SECTION 47. This rule shall be effective for any policy subject to s. Ins 3.39 which is solicited or issued after the effective date of this rule.

Dated at Madison, Wisconsin, this 19th day of May 1992, ~~1991.~~

Robert D. Haase
Commissioner of Insurance

RECEIVED
MAY 20 1992
Revisor of Statutes
Bureau

701R54
05/14/92