Chapter Ins 25

MEDICARE SUPPLEMENT POLICY TRANSITION REQUIREMENTS

Note: Chapter Ins 25 was created as an emergency rule effective September 6, 1988.

Ins 25.01 General. (1) PURPOSE AND FINDINGS. The purpose of this chapter is to assure the orderly implementation and modification of Medicare supplement insurance benefits and premiums due to changes in the federal Medicare program brought about by P.L. 100-360; to provide for the reasonable standardization of the coverage, terms, and benefits of Medicare supplement policies; to facilitate public understanding of these policies; to eliminate provisions contained in these policies which may be misleading or confusing; to eliminate policy provisions which may duplicate Medicare benefits; to provide full disclosure of policy benefits and benefit changes; and to provide for premium refunds and credits associated with benefits duplicating Medicare program benefits. This chapter is issued pursuant to the authority vested in the commissioner under ss. 601.41 (3), 628.34 (12), 628.38, and 632.81, Stats.

(2) APPLICABILITY AND SCOPE. (a) This regulation shall take precedence over other rules and requirements relating to Medicare supplement policies only to the extent necessary to assure that benefits are not duplicated, that applicants receive adequate notice and disclosure of changes in Medicare supplement policies, that appropriate premium adjustments are made in a timely manner, and that premiums are reasonable in relation to benefits.

(b) Except as otherwise provided, this regulation shall apply to all Medicare supplement policies and certificates in force, delivered, issued in this state, or which are otherwise subject to the jurisdiction of this state on or after the effective date of this section.

History: Cr. Register January, 1989, No. 397, eff. 2-1-89.

Ins 25.02 Definitions (1) "Advertisement" has the meaning set forth in s. Ins. 3.27 (5) (a).

(2) "Applicant" means:

(a) A person who seeks to contract for insurance benefits under an individual Medicare supplement policy, and

(b) A proposed certificate holder under a group Medicare supplement policy.

(3) "Certificate" means a written summary of policy provisions issued to each group member under a group Medicare supplement policy.

(4) "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.

(5) "Medicare Supplement Policy" means a policy as defined in ss. 600.03 (28p) or 600.03 (28r).

History: Cr. Register January, 1989, No. 397, eff. 2-1-89.

Ins 25.03 Benefit conversion requirements. (1) Effective January 1, 1989, no Medicare supplement policy or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

(2) (a) On or before December 1 of 1988, 1989, and 1990, every insurer providing Medicare supplement policy coverage shall mail to its Medicare supplement policyholders and certificate holders a notice of modifications made to its Medicare supplement policies. The notice shall be in the format shown in Appendices 1, 2, and 3 and shall:

1. Describe revisions to the Medicare program and each modification made to the Medicare supplement policy;

2. Describe any premium adjustment due to changes in Medicare benefits;

3. Describe all benefit modifications and any premium adjustments in outline form and in clear and simple terms; and

4. Include an approved rider, endorsement, or policy form necessary to eliminate any benefit under the policy that duplicates benefits provided by Medicare.

5. Be printed in at least 10 point type.

(b) At the time of or in connection with the notice required under par. (a), no agent or insurer may solicit other insurance or make any modifications to an existing Medicare supplement policy except to the extent necessary to eliminate duplication of Medicare benefits or to make modifications necessary under the policy to provide an indexed benefit adjustment.

(c) No insurer may require any person covered under a Medicare supplement policy which was in force prior to January 1, 1989, to purchase additional coverage.

(d) Every insurer shall review premiums annually and, if necessary, adjust the premium to produce an expected loss ratio which conforms to the minimum loss ratio standards for each policy form and results in a loss ratio at least as great as that originally anticipated for each policy form. No insurer shall make any premium adjustment which would modify the loss ratio experience under the policy, other than the adjustments described in this section, at any time other than upon the renewal date of the policy. An insurer shall make premium adjustments in the form of refunds or premium credits. If a credit is given, it shall be given no later than upon renewal. If a refund is provided, it shall be given no later than 60 days after the next following renewal date.

(e) Prior to October 1 of 1988, 1989, and 1990, every insurer providing Medicare supplement coverage shall file with the commissioner:

1. Appropriate premium rate adjustments necessary to produce loss ratios as originally anticipated and required for the applicable policies. The submission shall be in the format of Appendix 4 and include support-

ing documents required under ch. 625, Stats., and s. Ins. 3.39 as necessary to justify the adjustment.

2. Any riders, endorsements, or policy forms needed to eliminate duplications of Medicare benefits. These filings shall utilize the procedures specified in s. Ins. 6.05 and provide a clear description of the changes to the policy.

History: Cr. Register January, 1989, No. 397, eff. 2-1-89.

Ins 25.04 Requirements for new policies and certificates. (1) On or after January 1, 1989, no insurer shall issue any Medicare supplement policy or certificate which provides benefits duplicated by Medicare. No Medicare supplement policy or certificate shall provide less benefits than those required under s. Ins. 3.39.

(2) Prior to marketing any Medicare supplement policy with an effective date after December 31, 1988, an insurer shall file and obtain approval for each Medicare supplement insurance policy form and outline of coverage.

(3) The filing required under sub. (2) shall provide for loss ratios which are in compliance with s. Ins. 3.39.

History: Cr. Register January, 1989, No. 397, eff. 2-1-89.

Ins. 25.05 Filing requirements for advertising. Prior to use in this state, every insurer shall file with the commissioner a copy of any advertisement used in connection with the sale of Medicare supplement policies issued with an effective date after December 31, 1988. Insurers shall submit the advertisements using forms specified in Appendices 5 and 6. The advertisements shall comply with all applicable laws of this state.

History: Cr. Register January, 1989, No. 397, eff. 2-1-89.

APPENDIX 1

NOTE: This form is to be used for the Medicare changes taking effect on January 1, 1989. Insurers providing Medicare replacement coverage should substitute the words "Medicare Replacement" for "Medicare Supplement."

(COMPANY NAME)

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT INSURANCE - 1989

THIS NOTICE IS FOR INFORMATION ONLY. YOU NEED NOT DO ANYTHING.
YOUR INSURANCE COVERAGE WILL CONTINUE AS LONG AS YOU PAY YOUR PREMIUM.

YOUR HEALTH CARE BENEFITS PROVIDED BY THE FEDERAL MEDICARE PROGRAM WILL CHANGE ON JANUARY 1, 1989. ADDITIONAL CHANGES TO MEDICARE BENEFITS WILL OCCUR IN THE FOLLOWING YEARS. YOUR MEDICARE SUPPLEMENT COVERAGE PROVIDED BY (COMPANY NAME) WILL ALSO CHANGE. THE FOLLOWING OUTLINE BRIEFLY DESCRIBES THE CHANGES TO MEDICARE AND TO YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ CAREFULLY!

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
MEDICARE PART A	In 1988, Medicare Pays Per Benefit Period	Effective January 1, 1989, Medicare Pays Per Calendar Year	Your 1988 Coverage Pays Per Benefit Period	Effective January 1, 1989, Your Policy Pays Per Calendar Year
HOSPITAL SERVICES AND SUPPLIES	First 60 days - All but $540 61st to 90th day - All but $135 a day 91st to 150th day - All but $270 a day Beyond 150th day - Nothing	Unlimited number of hospital days after $564 deductible		
SKILLED NURSING HOME	Requires a 3-day prior hospital stay and admission to the facility within 30 days after hospital discharge	There is no prior hospital stay required for this benefit		