08-112

ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE REPEALING, RENUMBERING, RENUMBERING AND AMENDING, AMENDING, REPEALING AND CREATING AND CREATING A RULE

To renumber Ins 3.39 (1) (c); and Appendices 4 through 8;

To amend Ins 3.13 (2) (j) 3.; 3.29 (3) (a) and (7) (b); 3.39 (1) (a) and (b); (3) (q), (v), (w); (4) (intro.) and (a) 3., 8., 17.; (5) (title) and (intro.); (6) (intro.); (7) (a) and (d); (8) (c); (9) (b); (14) (title) and (d) 3.; (15); (23) (d); (24) (g); (26) (b); (30) (a) 1. and 2., (b) (intro.); (31) (a); (34) (e); Appendix 1 and 6;

To repeal and recreate Ins 3.39 Appendices 2 and 3; and

To create Ins 3.39 (1) (c); (3) (ce) and (cs); (4s); (5m); (14m); (17); (18); (30m); (34) (ez); (35); (36); and Appendices 4 and 5, Wis. Adm. Code,

Relating to Medicare supplement and replacement insurance.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. **Statutes interpreted:**

   ss. 185.983 (1m), 600.03, 601.01 (2), 609.01 (1g) (b), 625.16, 628.34 (12), 628.38, 631.20 (2), 632.73 (2m), 632.76 (2) (b) and 632.81, 632.895 (6) and (9), Wis. Stats.

2. **Statutory authority:**

   ss. 601.41, 625.16, 628.34, 628.38, 632.73, 632.76, 632.81, Wis. Stats.

3. **Explanation of OCI's authority to promulgate the proposed rule under these statutes:**

The statutes all relate to the commissioner's authority to promulgate rules regulating the business of insurance as it relates to Medicare supplement and Medicare replacement insurance products. Specifically, ss. 601.41, 625.16, 628.38, 632.73, 632.76, and 632.81, Wis. Stats., permit the commissioner to promulgate rules regulating various aspects of Medicare supplement and Medicare replacement products while s. 628.34, Wis. Stats., authorizes the

commissioner to promulgate rules governing disclosure requirements and unfair marketing practices for disability policies, which includes Medicare supplement and Medicare replacement products.

4. Related statutes or rules:

The Centers for Medicare & Medicaid Services (CMS) required the National Association of Insurance Commissioners (NAIC) to make conforming changes to the Medigap model regulation by incorporating changes necessary to implement requirements of the Genetic Information Nondiscrimination Act of 2008 (GINA Public Law 110-233) and delegated the function of implementing the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Public Law 110-175) to NAIC. The GINA law requires states to adopt necessary changes by July 1, 2009 and to have regulations in place for MIPPA by September 24, 2009. States are required to adopt the NAIC model revision in order to continue to regulate the Medigap marketplace.

CMS delegates enforcement of MIPPA and GINA and the underlying Medicare supplement and Medicare replacement insurance products to the states that have incorporated into the state's insurance regulations, the NAIC Model Act. To date Wisconsin has passed several NAIC Model Acts through statute and most recently administrative rule governing the Medicare supplement and Medicare replacement products. In Wisconsin Medicare supplement and Medicare replacement products are currently regulated through s. Ins 3.39, Wis. Adm. Code, inclusive of the appendices. The proposed rule modifies s. Ins 3.39, Wis. Adm. Code, and several appendices in order to comply with the MIPPA, GINA and the NAIC requirements, to the extent necessary, and updates the appendices to reflect those changes.

5. The plain language analysis and summary of the proposed rule:

The proposed rule implements modifications delineated by the NAIC Medicare Supplement Insurance Minimum Standards Model Act that includes modifications to comply with

both GINA and MIPPA. Medigap policies are policies purchased by Medicare beneficiaries to cover Medicare deductibles, coinsurance, copayments and selected services that Medicare does not cover. Medicare establishes eligibility rules, benefits and coverage limits. The proposed rule incorporates the NAIC Model Act into Wisconsin's current Medicare supplement and Medicare replacement rules.

The proposed rule contains a new paragraph that specifically implements the GINA requirements as they relate to Medicare supplement or replacement plans. The proposed rule updates requirements relating to the submission of form filings and advertisements to the Office of the Commissioner of Insurance (OCI) including the repeal and recreation of Appendices 2 and 3 and modification of s. Ins 3.39 (15).

The proposed rule implements the changes to the Medicare supplement benefits that are to be effective by June 1, 2010 in accordance with MIPPA. Specifically, although Wisconsin is waived by CMS from offering specific Medicare supplement plans, the OCI is proposing to incorporate the benefits contained within the federal newly created standardized plans labeled "M" and "N", into two new rider options. These riders will create a Medicare Part A 50% deductible with no out-of-pocket maximum limitation and will create a Medicare Part B 100% deductible with copayment requirements for office and emergency room visits.

While the federal standardized plans eliminate the preventive health care coverage, the proposed rule retains those benefits. Also, although the standardized plans are first incorporating a hospice care benefit while the OCI has required a hospice benefit for over 3 years and will retain the benefit for policies that become effective on or after June 1, 2010. The proposed rule includes a newly created paragraph to address issuers' use of new or innovative benefits as contained in the NAIC Model Act.

For clarity, the proposed rule renumbers existing appendices to include newly created Appendices 2 through 6 for the Medicare supplement plans that are effective on or after June 1, 2010. The new appendices follow product lines with one appendix dedicated to premium information and various disclosures. Parallel cites are proposed to ease use of the new regulations by creating s. Ins. 3.39 (4s), (5m) and (30m).

The proposed rule preserves the regulatory oversight of products primarily sold to Wisconsin seniors and maintains rigorous standards for disclosure of benefits, consumer rights and marketing practices. In furthering this oversight, the proposed rule includes specific requirements for issuers that are marketing and selling insurance products intended to wrap around or fill gaps in Medicare Advantage products. The proposed rule will require these insurance products to comply with the Medicare supplement and replacement regulations.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

The NAIC Model Act implements MIPPA, GINA and previous federal Medicare supplement and Medicare replacement regulations. CMS permitted NAIC a narrow period of time to amend its model act and permitted states to implement the updated NAIC Model Act to retain the regulatory oversight of Medicare supplement and replacement insurance for the modified products that are to be effective on or after June 1, 2010. The department of labor and CMS require implementation of the requirements contained in GINA by July 1, 2009.

7. Comparison of similar rules in adjacent states as found by OCI:

Iowa: Iowa makes available to its Medicare beneficiaries Medigap policies A through J as required by the Medicare reform provisions under OBRA 1990 and the prior NAIC Model Regulation. Iowa will have to amend its regulations to create new Medigap plans M and N, and to incorporate the hospice care benefit as well as

the new and innovative benefit requirements as required by MIPPA. Iowa will also have to comply by implementing the GINA requirements.

Illinois: Illinois makes available to its Medicare beneficiaries Medigap policies A through J as required by the Medicare reform provisions under OBRA 1990 and the prior NAIC Model Regulation. Illinois will have to amend its regulations to create new Medigap plans M and N, and to incorporate the hospice care benefit as well as the new and innovative benefit requirements as required by MIPPA. Illinois will also have to comply by implementing the GINA requirements.

Minnesota: Minnesota, like Wisconsin, received a waiver from the federal standardization regulations. Minnesota makes available to its Medicare beneficiaries two standardized policies (basic and extended basic). Minnesota will have to amend its Medicare supplement regulations to create two cost-sharing plans. It also will have to amend its regulations to include the prohibitions and other changes under GINA.

Michigan: Michigan makes available to its Medicare beneficiaries Medigap policies A through J as required by the Medicare reform provisions under OBRA 1990 and the prior NAIC Model Regulation. Michigan will have to amend its regulations to create new Medigap plans M and N, and to incorporate the hospice care benefit as well as the new and innovative benefit requirements as required by MIPPA. Michigan will also have to comply by implementing the GINA requirements.

8. A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:

OCI review of complaints, NAIC models, issuer's financial information CMS data indicates that Medicare currently covers 40 million Americans, 814,183 of whom are Wisconsin

residents as of 2004. An estimated 27 percent of Medicare beneficiaries are covered by Medigap policies.

Information collected by the OCI indicates that 75 insurance companies offer Medicare supplement, Medicare cost and Medicare select (Medigap) policies to Wisconsin consumers eligible for Medicare due to age or disability. In addition, there are 25 insurance companies that have Medigap policyholders although the companies no longer market Medigap coverage in Wisconsin. At year end 2007, there were 247,142 Wisconsin Medicare beneficiaries with Medigap policies. The majority of these Wisconsin Medicare beneficiaries have Medigap policies that will be affected by the Medigap reforms under the MIPPA and GINA.

A 2000 report by CMS, Office of Research, Development, and Information, based on 2007 Medicare data indicates that Medicare paid 54-56% of the health care expenses of persons 65 or over, and private health insurance, including Medicare supplement policies paid 16% of these health care expenses. The report indicated that overall annual medical expenses in 2005 per Medicare beneficiary equaled $6,697.

9. Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:

OCI reviewed financial statements and other reports filed by life, accident and health issuers and determined that none qualifies as a small business. Wisconsin currently has 75 insurance companies offering Medicare supplement, Medicare cost and Medicare select insurance plans. None of these issuers meets the definition of a small business under s. 227.114, Wis. Stats.

There maybe limited effects on intermediaries, however the requirement will not be significant and will mainly be comprised of learning new products and options for seniors.

10. See the attached Private Sector Fiscal Analysis.

The proposed rule will not significantly impact the private sector. Issuers offering Medigap policies (Medicare supplement, Medicare cost, and Medicare select policies) will incur costs associated with developing new Medigap policies and marketing materials, mailing riders and explanatory materials to existing policyholders and reprogramming claim processing systems. However, these costs are offset by the issuers' ability to continue offering Medigap policies to Wisconsin consumers and will not be significant. Intermediaries will need to use the newly developed forms and may incur nominal printing costs if the issuers do not provide forms to the agents, but such costs will not be significant.

11. A description of the Effect on Small Business:

This rule does not have a significant impact on regulated small businesses as defined in s. 227.114 (1), Wis. Stat., including intermediaries. OCI maintains a database of all licensed issuers in Wisconsin. The database includes information submitted by the companies related to premium revenue and employment. In an examination of this database, OCI identified that 75 insurance companies offer Medicare supplement, Medicare cost and Medicare select (Medigap) policies to Wisconsin consumers eligible for Medicare due to age or disability and none of those companies qualify by definition as a small business. In addition, 25 insurance companies have Medigap policyholders although the companies no longer market Medigap coverage in Wisconsin. Again, none of these 25 companies qualifies by definition as a small business. Although affected by this proposed rule change, intermediaries qualifying as small businesses may be affected but such effect will not be significant as previously described.

12. Agency contact person:

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at: **http://oci.wi.gov/ocirules.htm**

or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: inger.williams@wisconsin.gov
Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on the 14th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins 339
Office of the Commissioner of Insurance
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Web site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

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

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

SECTION 2. Ins 3.29 (3) (a) and (7) (b) are amended to read:

Ins 3.29 (3) (a) Group, blanket or group type, except Medicare supplement and replacement insurance subject to s. Ins 3.39 (4), (4s), (5), (5m) and (7).

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

SECTION 3. Ins 3.39 (1) (a) and (b) are amended to read:

Ins 3.39 (1) PURPOSE. (a) This section establishes requirements for health and other disability insurance policies or certificates primarily sold to Medicare eligible persons. Disclosure provisions are required for other disability policies or certificates sold to Medicare eligible person because such policies or certificates frequently are represented to, and purchased by, the Medicare eligible as supplements to Medicare products, including Medicare Advantage and Medicare Prescription Drug plans.

(b) This section seeks to reduce abuses and confusion associated with the sale of disability insurance to Medicare eligible persons by providing ~~for~~ reasonable standards. The disclosure requirements and established benefit standards are intended to provide to Medicare eligible persons guidelines that they can use to compare disability insurance policies and certificates and to aid them in the purchase of policies and certificates intended to supplement Medicare and Medicare ~~supplement and Medicare replacement health insurance which is~~ Advantage plans that are suitable for their needs. This section is designed not only to improve the ability of the Medicare eligible consumer to make an informed choice when purchasing disability insurance, but also to assure the Medicare eligible persons of this state that the commissioner will not approve a policy or certificate as "Medicare supplement" or as a "Medicare replacement" unless it meets the requirements of this section.

SECTION 4. Ins 3.39 (1) (c) is renumbered (d):

SECTION 5. Ins 3.39 (1) (c) is created to read:

3.39 (1) (c) Any disability insurance policy or certificate that is designed to reduce or eliminate gaps arising from the coverages in a Medicare Advantage or Medicare Part D Prescription Drug plan shall comply with this section, and pursuant to s. 104 (c) of Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (42 U.S.C. 1302, 1395w-101 et. seq.), policies and certificates that are advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare Advantage plans shall comply with Medicare supplement requirements of s. 1882 (o) the federal Social Security Act (42 U.S.C. Section 1395 et. seq.).

SECTION 6. Ins 3.39 (3) (ce) and (cs) are created to read:

Ins 3.39 (3) (ce) "Balance bill" means seeking: to bill, charge, or collect a deposit, remuneration or compensation from; to file or threaten to file with a credit reporting agency; or to have any recourse against an enrollee or any person acting on the enrollee's behalf for health care costs for which the enrollee is not liable. The prohibition on recovery does not affect the liability of an enrollee for any deductibles, coinsurance or copayments, or for premiums owed under the policy or certificate.

(cs) "Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

SECTION 7. Ins 3.39 (3) (q), (v), and (w), (4) (intro.) and (a) 3., 8. and 17., are amended to read:

Ins 3.39 (3) (q) "Medicare" shall be defined in the policy or certificate. "Medicare" may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth congress of the United States of America and

popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof, or words of similar import.

(v) "Medicare replacement coverage" means coverage that meets the definition in s. 600.03 (28p), Stats., as interpreted by sub. (2) (a), and that conforms to subs. (4), (4s), and (7). "Medicare replacement coverage" includes Medicare cost and Medicare Advantage plans.

(w) "Medicare supplement coverage" means coverage that meets the definition in s. 600.03 (28r), Stats., as interpreted by sub. (2) (a), and that conforms to subs. (4), (4s), (5), (5m), (6), ~~and~~ (30), and (30m). "Medicare supplement coverage" includes Medicare supplement and Medicare select plans but does not include coverage under Medicare Advantage plans established under Medicare Part C or Outpatient Prescription Drug plans established under Medicare Part D.

Ins 3.39 (4) MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY AND CERTIFICATE REQUIREMENTS FOR POLICIES AND CERTFICIATES EFFECTIVE DATES PRIOR TO JUNE 1, 2010. Except as explicitly allowed by subs. (5), (7) and (30), no disability insurance policy or certificate shall relate its coverage to Medicare or be structured, advertised, solicited, delivered or issued for delivery in this state after December 31, 1990 for policies or certificates with effective dates prior to June 1, 2010, as a Medicare supplement policy or certificate or as a Medicare replacement policy or certificate, as defined in s. 600.03 (28p) (a) and (c), Stats., unless it complies with the following:

(a) 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" that 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) (~~p~~g).

8. Changes benefits automatically to coincide with any changes in the applicable Medicare deductible amount, coinsurance, and copayment percentage factors, although there may be a corresponding modification of premiums in accordance with the policy or certificate provisions and ch. 625, Stats.

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

SECTION 8. Ins 3.39 (4s) is created to read:

3.39 (4s) MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY AND CERTIFICATE REQUIREMENTS FOR POLICIES AND CERTIFICATES WITH EFFECTIVE DATES ON OR AFTER JUNE 1, 2010. Except as explicitly allowed by subs. (5m) and (30m), no disability insurance policy or certificate shall relate its coverage to Medicare or be structured, advertised, marketed or issued for delivery in this state on or after June 1, 2010, as a Medicare supplement or as a Medicare replacement policy or certificate, as defined in s. 600.03 (28p) (a) and (c), Stats., unless it complies with the following:

(a) The policy or certificate:

1. Provides only the coverage set out in sub. (5m) or (30m) and applicable statutes and contains no exclusions or limitations other than those permitted by sub. (8). No issuer may issue a Medicare cost or Medicare select policy or certificate without prior approval from the commissioner and compliance with sub. (30m).

2. Discloses on the first page any applicable preexisting conditions limitation, contains no preexisting condition waiting period longer than 6 months and does not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

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” that 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) (q).

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

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 non-payment of premium. The policy or certificate may not be cancelled or nonrenewed by the issuer on the grounds of deterioration of health. The policy or certificate may be cancelled only for nonpayment of premium or material misrepresentation. If the policy or certificate is issued by a health maintenance organization, the policy or certificate may, in addition to the above reasons, be cancelled or nonrenewed by the issuer if the insured moves out of the service area.

6. Provides that termination of a Medicare supplement or Medicare cost policy or certificate shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force, although the extension of benefits may be predicated upon the continuous total disability of the insured, limited to the duration of the policy or certificate benefit period, if any, or payment of the maximum benefits. Receipt of the Medicare Part D benefits may not be considered in determining a continuous loss.

7. Contains statements on the first page and elsewhere in the policy or certificate that satisfy the requirements of s. Ins 3.13 (2) (c), (d) and (e), and clearly states on the first page or schedule page the duration of the term of coverage for which the policy or certificate is issued

and for which it may be renewed. The renewal period cannot be less than the greatest of the following: 3 months, the period for which the insured has paid the premium, or the period specified in the policy or certificate.

8. Changes benefits automatically to coincide with any changes in the applicable Medicare deductible amount, coinsurance and copayment percentage factors, although there may be a corresponding modification of premiums in accordance with the policy or certificate provisions and ch. 625, Stats.

9. Prominently discloses any limitations on the choice of providers or geographical area of service.

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. (5m) or (30m).

11. Contains text that is plainly printed in black or blue ink the size of which is uniform and not less than 10-point type with a lower-case unspaced alphabet length not less than 120-point type.

12. Contains a provision describing the review and appeal procedure for denied claims required by s. 632.84, Stats., and a provision describing any grievance rights required by s. 632.83, Stats., applicable to Medicare supplement and Medicare replacement policies or certificates.

13. Is approved by the commissioner.

14. Contains no exclusion, limitation, or reduction of coverage for a specifically named or described condition after the policy or certificate effective date.

15. Provides for midterm cancellation at the request of the insured and provides that, if an insured cancels a policy or certificate midterm or the policy or certificate terminates midterm

because of the insured's death, the issuer shall issue a pro rata refund to the insured or the insured's estate.

16. Except for permitted preexisting condition clauses as described in subd. 2., no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate 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 that duplicate benefits provided by Medicare.

18. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or 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.

19. If the suspension in subd. 18. 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, 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.

20. Each Medicare supplement policy or certificate shall provide, and contain within the policy or certificate, that benefits and premiums under the policy or certificate shall be suspended for any period that may be provided by federal regulation, at the request of the policyholder or certificateholder if the policyholder or certificateholder is entitled to benefits under section 226 (b) of the Social Security Act and is covered under a group health plan, as

defined in section 1862 (b) (1) (A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy or certificate shall be automatically reinstituted, effective as of the date of loss of coverage, if the policyholder or certificateholder provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

21. Reinstitution of such coverages:

a. May not provide for any waiting period with respect to treatment of preexisting conditions.

b. Shall provide for resumption of coverage that was in effect before the date of suspension in subd. 18.

c. 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.

22. May not use an underwriting standard for persons who are under age 65 that is more restrictive than that used for persons age 65 and above.

(b) The outline of coverage for the policy or certificate shall comply with all of the following:

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

2. Complies with s. Ins 3.27.

3. Is substituted to describe properly the policy or certificate as issued, if the outline provided at the time of application did not properly describe the coverage that was issued. The

substituted outline shall accompany the policy or certificate when it is delivered and shall contain the following statement in no less than 12-point type and immediately above the company name: “NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued.”

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

5. Is substantially in the format prescribed in Appendices 3 through 6 to this section for the appropriate category and printed in no less than 12-point type.

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

7. Contains a listing of the required coverage as set out in sub. (5m) (d) and the optional coverage as set out in sub. (5m) (e), and the annual premiums for selected coverage, substantially in the format of sub. (11) in Appendix 2 to this section.

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

(c) Any rider or endorsement added to the policy or certificate shall conform to the following:

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

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

3. Shall only provide coverage as defined in sub. (5m) (e) or provide coverage to meet Wisconsin mandated benefits.

(d) The schedule of benefits page or the first page of the policy or certificate contains a listing giving the coverages and both the annual premium in the format shown in sub. (11) of Appendix 2 to this section and modal premium selected by the applicant.

(e) The anticipated loss ratio for any new policy or certificate form, that is, the expected percentage of the aggregate amount of premiums earned that will be returned to insureds in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy 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 or certificate form provides coverage, in accordance with accepted actuarial principles and practices.

2. Is submitted to the commissioner along with the policy or certificate 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 or certificate form will not be approved unless the anticipated loss ratio along with the rates and actuarial demonstration show compliance.

(f) As regards subsequent rate changes to the policy or certificate form, the issuer:

1. Files such changes on a rate change transmittal form in a format specified by the commissioner.

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 or certificate that would violate sub. (16) (d).

SECTION 9. Ins 3.39 (5) (title) and (intro.), is amended to read:

Ins 3.39 (5) AUTHORIZED MEDICARE SUPPLEMENT POLICY AND CERTIFICATE DESIGNATION, CAPTIONS, REQUIRED COVERAGES, AND PERMISSIBLE ADDITIONAL BENEFITS FOR POLICIES OR CERTIFICATES EFFECTIVE PRIOR TO JUNE 1, 2010. For a policy or certificate to meet the requirements of sub. (4), that is issued or effective after December 31, 1990, and prior to June 1, 2010, it shall contain the authorized designation, caption and required coverage. A health maintenance organization shall place the letters HMO in front of the required designation on any approved Medicare supplement policy or certificate. A Medicare supplement policy or certificate shall include all of the following:

SECTION 10. Ins 3.39 (5m) is created to read:

(5m) AUTHORIZED MEDICARE SUPPLEMENT POLICY AND CERTIFICATE DESIGNATION, CAPTIONS, REQUIRED COVERAGES, AND PERMISSIBLE ADDITIONAL BENEFITS FOR POLICIES OR CERTIFICATES WITH EFFECTIVE DATES ON OR AFTER JUNE 1, 2010. (a) 1. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued in this state. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. Benefit standards applicable to Medicare supplement policies and certificates with effective dates prior to June 1, 2010 remain subject to the applicable requirements contained in sub. (5).

2. For a policy or certificate to meet the requirements of sub. (4s), it shall contain the authorized designation, caption and required coverage. A health maintenance organization shall place the letters HMO in front of the required designation on any approved Medicare supplement policy or certificate. A Medicare supplement policy or certificate shall include all of the following:

(b) The designation: MEDICARE SUPPLEMENT INSURANCE.

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

(d) The following required coverages shall be referred to as "Basic Medicare Supplement Coverage":

1. Coverage of at least 175 days per lifetime for inpatient psychiatric hospital care upon exhaustion of Medicare hospital inpatient psychiatric coverage.

2. Coverage of coinsurance or copayments for Medicare Part A eligible expenses in a skilled nursing facility from the 21st through the 100th day in a benefit period.

3. Coverage for all Medicare Part A eligible expenses for the first 3 pints of blood or equivalent quantities of packed red blood cells to the extent not covered by Medicare.

4. Coverage of coinsurance or copayments for all Medicare Part A eligible expenses for hospice and respite care.

5. Coverage of coinsurance or copayment for Medicare Part B eligible expenses to the extent not paid by Medicare, or in the case of hospital outpatient department services paid under a prospective payment system including outpatient psychiatric care, regardless of hospital confinement, subject to the Medicare Part B calendar year deductible.

6. Coverage for the usual and customary home care expenses to a minimum of 40 visits per 12-month period as required under s. 632.895 (1) and (2), Stats., and s. Ins 3.54.

7. Coverage for skilled nursing care and kidney disease treatment as required under s. 632.895 (3) and (4), Stats. Coverage for skilled nursing care shall be in addition to the required coverage under subd. 1, payment of coinsurance or copayment for Medicare Part A eligible skilled nursing care may not count as satisfying the coverage requirement of at least 30 days of non-Medicare eligible skilled nursing care under s. 632.895 (3), Stats.

8. In group policies, coverage for nervous and mental disorder and alcoholism and other drug abuse coverage as required under s. 632.89, Stats.

9. Coverage in full for all usual and customary expenses for chiropractic services required by s. 632.87 (3), Stats. Issuers are not required to duplicate benefits paid by Medicare.

10. Coverage of the first 3 pints of blood payable under Medicare Part B.

11. Coverage of Medicare Part A eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

12. Coverage of Medicare Part A eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days.

13. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of all Medicare Part A eligible expenses for hospitalization not covered by Medicare for an additional 365 days to the extent the hospital is permitted to charge Medicare by federal law and regulation and subject to the Medicare reimbursement rate and a lifetime maximum benefit. The provider shall accept the issuer's payment as payment in full and may not balance bill the insured.

14. Coverage in accordance with s. 632.895 (6), Stats., for treatment of diabetes including non-prescription insulin or any other non-prescription equipment and supplies for the treatment of diabetes, but not including any other outpatient prescription medications. Issuers are not required to duplicate expenses paid by Medicare.

15. Coverage for preventive health care services not covered by Medicare and as determined to be medically appropriate by an attending physician. These benefits shall be included in the basic policy or certificate. Reimbursement shall be for the actual charges up to 100% of the Medicare approved amount for each service, as if Medicare were to cover the service, as identified in the American Medical Association Current Procedural Terminology codes, to a minimum of $120 annually under this benefit. This benefit may not include payment for any procedure covered by Medicare.

16. Coverage in full for all usual and customary expenses of hospital and ambulatory surgery center charges and anesthetics for dental care required by s. 632.895 (12), Stats. Issuers are not required to duplicate benefits paid by Medicare.

17. Coverage in full for all usual and customary expenses for breast reconstruction required by s. 632.895 (13), Stats. Issuers are not required to duplicate benefits paid by Medicare.

(e) Permissible additional coverage may only be added to the policy or certificate as separate riders. The issuer shall issue a separate rider for each additional coverage offered. Issuers shall ensure that the riders offered are compliant with MMA, each rider is priced separately, available for purchase separately at any time, subject to underwriting and the preexisting limitation allowed in sub. (4s) (a) 2., and may consist of the following:

1. Coverage of 100% of the Medicare Part A hospital deductible. The rider shall be designated: MEDICARE PART A DEDUCTIBLE RIDER.

2. Coverage of 50% of the Medicare Part A hospital deductible per benefit period with no out-of-pocket maximum. The rider shall be designated: MEDICARE 50% PART A DEDUCTIBLE RIDER.

3. Coverage of home health care for an aggregate of 365 visits per policy or certificate year as required by s. 632.895 (1) and (2), Stats. The rider shall be designated as: ADDITIONAL HOME HEALTH CARE RIDER.

4. Coverage of 100% of the Medicare Part B medical deductible. The rider shall be designated as: MEDICARE PART B DEDUCTIBLE RIDER.

5. Coverage of 100% of the Medicare Part B medical deductible. The insured is subject to copayment or coinsurance of no more than $20 per office visit and no more than $50 per emergency room visit that is in addition to the Medicare Part B medical deductible and in addition to out-of-pocket maximums. The emergency room copayment or coinsurance fee shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense. The rider shall be designated as: MEDICARE PART B COPAYMENT OR COINSURANCE DEDUCTIBLE RIDER.

6. Coverage of the difference between Medicare Part B eligible charges and the amount charged by the provider that shall be no greater than the actual charge or the limiting charge allowed by Medicare. The rider shall be designated as: MEDICARE PART B EXCESS CHARGES RIDER.

7. Coverage for services obtained outside the United States. An issuer that offers this benefit may not limit coverage to Medicare deductibles, coinsurance and copayments. Coverage may contain a deductible of up to $250. Coverage shall pay at least 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country; which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States for up to 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 EMERGENCY RIDER.

(f) For HMO Medicare select policies, only the benefits specified in sub. (30m) (p), (r) and (s), may be offered in addition to Medicare benefits.

(g) For the Medicare supplement 50% Cost-Sharing plans, only the following:

1. The designation: **MEDICARE SUPPLEMENT 50% COST-SHARING PLAN**.

2. Coverage of coinsurance or copayment for Medicare Part A hospital amount for each day used from the 61st through the 90th day in any Medicare benefit period.

3. Coverage of coinsurance or copayment of Medicare Part A hospital amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period.

4. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage for 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime limitation benefit of an additional 365 days.

5. Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subd. 12.

6. Coverage for 50% of the coinsurance or copayment amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subd. 12.

7. Coverage for 50% of coinsurance or copayments for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in subd. 12.

8. Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subd. 12.

9. Except for coverage provided in subd. 11., coverage for 50% of the coinsurance or copayment otherwise applicable under Medicare Part B after the policyholder or certificateholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described in subd. 12.

10. Coverage for 100% of the coinsurance or copayments for the benefits described in pars. (d) 1., 6., 7., 9., 14., 16., and 17., and (e) 3., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder or certificateholder pays the Medicare Part A and B deductibles and meets the out-of-pocket limitation described in subd. 12.

11. Coverage for 100% of the coinsurance or copayments for Medicare Part B preventive services after the policyholder or certificateholder pays the Medicare Part B deductible.

12. Coverage for 100% of all cost sharing under Medicare Part A or B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of [$4,440], indexed each year by the appropriate inflation adjustment specified by the Secretary.

(h) For the Medicare Supplement 25% Cost-Sharing plans, only the following:

1. The designation: **MEDICARE SUPPLEMENT 25% COST-SHARING PLAN**.

2. Coverage for 100% of the Medicare Part A hospital coinsurance or copayment amount for each day used from the 61st through the 90th day in any Medicare benefit period.

3. Coverage for 100% of the Medicare Part A hospital coinsurance or copayment amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period.

4. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage for 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime limitation benefit of an additional 365 days.

5. Coverage for 75% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subd. 12.

6. Coverage for 75% of the coinsurance or copayment amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subd. 12.

7. Coverage for 75% of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in subd. 12.

8. Coverage for 75%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subd. 12.

9. Except for coverage provided in subd. 11., coverage for 75% of the cost sharing otherwise applicable under Medicare Part B, after the policyholder or certificateholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described in subd. 12.

10. Coverage for 100% of the cost sharing for the benefits described in pars. (d) 1., 6., 7., 9., 14., 16., and 17., , and (e) 3., to the extent the benefits do not duplicate benefits paid by

Medicare and after the policyholder or certificateholder pays the Medicare Part A and B deductible and meets the out-of-pocket limitation described in subd. 12.

11. Coverage for 100% of the cost sharing for Medicare Part B preventive services after the policyholder or certificateholder pays the Medicare Part B deductible.

12. Coverage for 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of [$2,220], indexed each year by the appropriate inflation adjustment specified by the Secretary.

SECTION 11. Ins 3.39 (6) (intro.), (7) (a) and (d) are amended to read:

(6) USUAL, CUSTOMARY AND REASONABLE CHARGES. An issuer can only include a policy or certificate provision limiting benefits to the usual, customary and reasonable charge as determined by the issuer for coverages described in subs. (5) (c) 5., 8. and 13, or (5m) (d) 5., 8., and 13. If the issuer includes such a provision, the issuer shall:

(7) AUTHORIZED MEDICARE REPLACEMENT POLICY AND CERTIFICATE DESIGNATION, CAPTIONS AND REQUIRED MINIMUM COVERAGES. (a) A Medicare cost policy or certificate issued by an issuer that has a cost contract with CMS for Medicare benefits shall meet the standards and requirements of ~~subs.~~sub. (4) and shall contain all of the following required coverages, to be referred to as "Basic Medicare cost coverage" for a policy or certificate issued after January 1, 2005 with an effective date prior to June 1, 2010~~;~~.

(d) In addition to all other subsections that are applicable to Medicare cost policies, the marketing of Medicare cost policies shall comply with the requirements of Medicare supplement policies contained in subs. (15), (21), (24), and (25). The outline of coverage listed in Appendix 1 and the replacement form specified in Appendix ~~5~~7 shall be modified to accurately reflect the benefit, exclusions and other requirements that differ from Medicare supplement policies approved under sub. (5).

SECTION 12. Ins 3.39 (8) (c) and (9) (b) are amended to read:

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

(9) (b) *Disclosure statements*. The appropriate disclosure statement from Appendix ~~8~~10 shall be used on the application or together with the application for each coverage in pars. (c) to (e). The disclosure statement may not vary from the text or format including bold characters, line spacing, and the use of boxes around text contained in Appendix ~~8~~10 and shall use a type size of at least 12 points. The issuer may use either (a) or (aL), (b) or (bL), (c) or (cL) or (g) or (gL) providing the issuer uses the same disclosure statement for all policies of the type covered by the disclosure.

SECTION 13. Ins 3.39 (14) (title), (a), and (d) 3. are amended to read:

3.39 (14) (title) OTHER REQUIREMENTS FOR POLICIES OR CERTIFICATES WITH EFFECTIVE DATES PRIOR TO JUNE 1, 2010.

(a) Each issuer issuing policies or certificates with effective dates prior to June 1, 2010, may file and utilize only one individual Medicare supplement policy form, one individual Medicare select policy form, one individual Medicare replacement policy form and one group Medicare supplement policy form with any of the accompanying riders permitted in sub. (5) (i), unless the commissioner approves the use of additional forms and the issuer agrees to aggregate experience for the various forms in calculating rates and loss ratios.

(d) 3. This subsection shall not apply to the riders permitted in sub. (5) (~~j~~i).

SECTION 14. Ins 3.39 (14m) is created to read:

3.39 (14m) OTHER REQUIREMENTS FOR POLICIES OR CERTIFICATES WITH EFFECTIVE DATES ON OR AFTER JUNE 1, 2010. (a) Each issuer issuing policies or certificates with effective dates

on or after June 1, 2010, may file and utilize only one individual Medicare supplement policy or certificate form, one individual Medicare select policy or certificate form, one individual Medicare replacement policy or certificate form and one group Medicare supplement policy or certificate form with any of the accompanying riders permitted in sub. (5m) (e), unless the commissioner approves the use of additional forms and the issuer agrees to aggregate experience for the various forms in calculating rates and loss ratios.

(b) An issuer shall mail any refund or return of premium directly to the insured and may not require or permit delivery by an agent or other representative.

(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 complying with all of the following:

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 or certificate 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 Secretary, 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.

(d) Except as provided in subd. 1., an issuer shall continue to make available for purchase any policy form or certificate form issued after August 1, 1992 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 sub. (5m) (e).

(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 that 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 issuer may issue a Medicare supplement policy or certificate to an applicant 75 years of age or older, unless the applicant is subject to sub. (4m) or, prior to issuing coverage, the issuer either agrees not to rescind or void the policy or certificate except for intentional fraud in the application, or obtains one of the following:

1. A copy of a physical examination.

2. An assessment of functional capacity.

3. An attending physician's statement.

4. Copies of medical records.

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

(k) If an issuer nonrenews an insured who has a nonguaranteed renewable Medicare supplement policy or certificate with the issuer, the issuer shall at the time any notice of nonrenewal is sent to the insured, offer a currently available individual replacement Medicare

supplement policy or certificate and those currently available riders resulting in coverage substantially similar to coverage provided by the replaced policy or certificate without underwriting. This replacement shall comply with sub. (27).

(L) For policies or certificates issued with an effective date on or after June 1, 2010, issuers shall combine the Wisconsin experience of all policy or certificate forms of the same type (individual or group) for the purposes of calculating the loss ratio under sub. (16) (c) and rates. The rates for all such policies or certificates of the same type shall be adjusted by the same percentage. If the Wisconsin experience is not credible, then national experience can be considered.

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

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

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

Note: A copy of the advertisement filing form required under sub. (15), OCI 26-042, may be obtained at no cost from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, WI, 53707-7873 or from the OCI website address: http://oci.wi.gov.

SECTION 16. Ins 3.39 (17) and (18) are created to read:

3.39 (17) NEW OR INNOVATIVE BENEFITS. An issuer may offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards and is filed and approved by the commissioner. The new or innovative benefits may include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available and are cost-effective. New or innovative benefits may not include an outpatient prescription drug benefit. New or innovative benefits may not be used to change or reduce benefits, including a change of any cost-sharing provision.

3.39 (18) ELECTRONIC ENROLLMENT. (a) Any requirement that a signature of an insured be obtained by an agent or issuer offering any Medicare supplement or replacement plans shall be satisfied if all of the following are met:

1. The consent of the insured is obtained by telephonic or electronic enrollment by the issuer or group policyholder or certificateholder. A verification of the enrollment information shall be provided in writing to the applicant with the delivery of the policy or certificate.

2. The telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure the accuracy, retention and prompt retrieval of records as required pursuant to ch. 137, subch. II, Stats.

3. The telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure that the confidentiality of personal financial and health information as defined in s. 610.70, Stats., and ch. Ins 25 is maintained.

(b) The issuer shall make available, upon request of the commissioner, records that demonstrate the issuer's ability to confirm enrollment and coverage.

SECTION 17. Ins 3.39 (23) (d), (24) (g) and (26) (b) are amended to read:

3.39 (23) (d) The notice required by par. (c) for an issuer shall be provided in substantially the form as shown in Appendix ~~5~~7.

(24) (g) The terms "Medicare Supplement," "Medigap," "Medicare Wrap Around," and "Medicare Advantage Supplement" and words of similar import may not be used in any materials including advertisements as defined in s. Ins 3.27 (5) (a), unless the policy or certificate is issued in compliance with this section.

(26) (b) The items in par. (a) must be grouped by individual policyholder or certificateholder and listed on a form in substantially the same format as Appendix ~~7~~9 on or before March 1 of each year.

SECTION 18. Section Ins 3.39 (30) (a) 1. and 2., and (b) (intro.), are amended to read:

3.39 (30) (a) 1. This subsection shall apply to Medicare select policies and certificates issued prior to June 1, 2010.

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

(b) For the purposes of this ~~section~~subsection:

SECTION 19. Ins 3.39 (30m) is created to read:

(30m) MEDICARE SELECT POLICIES AND CERTIFICATES. (a) 1. This subsection shall apply to Medicare select policies and certificates issued on or after June 1, 2010.

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

(b) For the purposes of this subsection:

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 or certificate.

6. “Restricted network provision,” means any provision that 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 or certificate.

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

(d) A Medicare select issuer may 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 or certificateholders, 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 subd. 1. e., may not apply to supplemental charges, copayment, 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 all of the following:

a. The formal organizational structure.

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

c. The procedures for evaluating quality of care provided by network providers.

d. 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 after filing 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 may not restrict payment for covered services provided by non-network providers if both of the following occur:

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

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 or certificate 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, coinsurance or copayments, 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 in substantially the same format as Appendices 2 and 5 sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate to the following:

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

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 copayments or coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in the Medicare Select 50% and 25% Coverage Cost-Sharing plans offered by the Medicare select issuer pursuant to pars. (r) and (s).

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. (4s) (a) 10.

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

(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) 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 for Wisconsin mandated benefits. 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 or certificateholder 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 to the commissioner no later than each March 31st 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 this subdivision, a Medicare supplement policy or certificate shall 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 at-home recovery services or coverage for Medicare Part B excess charges.

(n) Medicare select policies and certificates shall provide for continuation of coverage in the event the Secretary 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, then the following apply:

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 this subdivision, a Medicare supplement policy or certificate shall 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 at–home recovery services or coverage for Medicare Part B excess charges.

(o) A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the CMS, for the purpose of evaluating the Medicare select program.

(p) Except as provided in par. (r) or (s), a Medicare select policy or certificate shall contain the following coverages:

1. The “basic Medicare supplement coverage” as described in sub. (5m) (d).

2. Coverage for 100% of the Medicare Part A hospital deductible as described in sub. (5m) (e) 1.

3. Coverage for home health care for an aggregate of 365 visits per policy or certificate year as described in sub. (5m) (e) 3.

4. Coverage for 100% of the Medicare Part B medical deductible as described in sub. (5m) (e) 4.

5. Coverage for preventive health care services as described in sub. (5m) (d) 15.

(q) Permissible additional coverage may only be added to the policy or certificate as separate riders. The issuer shall issue a separate rider for each additional coverage offered. Issuers shall ensure that the riders offered are compliant with MMA, each rider is priced separately, available for purchase separately at any time, subject to underwriting and the preexisting limitation allowed in sub. (4s) (a) 2., and may consist of the following:

1. Coverage for emergency care obtained outside of the United States as described in sub. (5m) (e) 7.

2. Coverage for 50% of the Medicare Part A hospital deductible with no out-of-pocket maximum as described in sub. (5m) (e) 2.

3. Coverage for 100% of the Medicare Part B medical deductible subject to copayment or coinsurance as described in sub. (5m) (e) 5.

(r) The Medicare Select 50% Cost-Sharing plans issued with an effective date on or after June 1, 2010, shall only contain the following coverages:

1. The designation: **MEDICARE SELECT 50% COST-SHARING PLAN**.

2. Coverage for 100% of the Medicare Part A hospital coinsurance or copayment amount for each day used from the 61st through the 90th day in any Medicare benefit period.

3. Coverage for 100% of the Medicare Part A hospital coinsurance or copayment amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period.

4. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage for 100% of the Medicare Part A eligible expenses for hospitalization

paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime limitation benefit of an additional 365 days.

5. Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subd. 12.

6. Coverage for 50% of the coinsurance or copayment amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subd. 12.

7. Coverage for 50% of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in subd. 12.

8. Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subd. 12.

9. Except for coverage provided in subd. 11., coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder or certificateholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described in subd. 12.

10. Coverage for 100% of the cost sharing for the benefits described in sub. (5m) (d) 1., 6., 7., 9., 14., 16., and 17., and (e) 3., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder or certificateholder pays the Medicare Part A and B deductible and meets the out-of-pocket limitation described in subd. 12.

11. Coverage for 100% of the cost sharing for Medicare Part B preventive services after the policyholder or certificateholder pays the Medicare Part B deductible.

12. Coverage for 100% of all cost sharing under Medicare Part A or B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of [$4,440] in 2010, indexed each year by the appropriate inflation adjustment specified by the Secretary.

(s) The Medicare Select 25% Coverage Cost-Sharing plans issued with an effective date on or after June 1, 2010, shall only contain the following coverages:

1. The designation: **MEDICARE SELECT 25% COST-SHARING PLAN**.

2. Coverage for 100% of the Medicare Part A hospital coinsurance or copayment amount for each day used from the 61st through the 90th day in any Medicare benefit period.

3. Coverage for 100% of the Medicare Part A hospital coinsurance or copayment amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period.

4. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage for 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime limitation benefit of an additional 365 days.

5. Coverage for 75% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subd. 12.

6. Coverage for 75% of the coinsurance or copayment amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subd. 12.

7. Coverage for 75% of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in subd. 12.

8. Coverage for 75%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subd. 12.

9. Except for coverage provided in subd. 11., coverage for 75% of the cost sharing otherwise applicable under Medicare Part B, except there shall be no coverage for the Medicare Part B deductible until the out-of-pocket limitation is met as described in subd. 12.

10. Coverage for 100% of the cost sharing for the benefits described in sub. (5m) (d) 1., 6., 7., 9., 14., 16., and 17., and (e) 3., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder or certificateholder pays the Medicare Part A and B deductible and meets the out-of-pocket limitation described in subd. 12.

11. Coverage for 100% of the cost sharing for Medicare Part B preventive services after the policyholder or certificateholder pays the Medicare Part B deductible.

12. Coverage for 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of [$2,220] in 2010, indexed each year by the appropriate inflation adjustment specified by the Secretary.

(t) A Medicare select policy or certificate may include permissible additional coverage as described in sub. (5m) (e) 2., 5., and 7. These riders, if offered, shall be added to the policy or certificate as separate riders or amendments and shall be priced separately and available for purchase separately.

(u) Issuers writing Medicare select policies or certificates shall additionally comply with subchs. I and III of ch. Ins 9.

SECTION 20. Ins 3.39 (31) (a) and (34) (e) (title) are amended to read:

3.39 (31) (a) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix ~~6~~8 for each type of policy or certificate form as described in sub. (14), including policies and certificates under sub. (14) (L) that are renewed after December 31, 1995.

(34) (e) *Products to which eligible persons are entitled prior to June 1, 2010.*

SECTION 21. Ins 3.39 (34) (ez) is created to read:

3.39 (34) (ez) *Products to which eligible persons are entitled on or after June 1, 2010.* The Medicare supplement or Medicare cost policy or certificate to which eligible persons are entitled under:

1. Paragraph (b) 1., 1m., 1r., 2., 3., and 4., is a Medicare supplement policy or certificate as defined in sub. (5m) along with any riders available or a Medicare select policy or certificate as defined in sub. (30m).

2. Paragraph (b) 5. is the same Medicare supplement policy or certificate in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy or certificate as described in subd. 1.

3. Paragraph (b) 6. and 8. is a Medicare supplement policy or certificate as described in sub. (5m) along with any riders available or a Medicare select policy or certificate as defined in sub. (30m).

4. Paragraph (b) 7., is a Medicare supplement policy or certificate as described in sub. (5m) along with any riders available or a Medicare select policy or certificate as defined in sub. (30m), that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy or certificate with the outpatient prescription drug coverage.

SECTION 22. Ins 3.39 (35) and (36) are created to read:

Ins 3.39 (35) EXCHANGE OF MEDICARE SUPPLEMENT POLICY. An issuer that submits and receives approval to offer a Medicare supplement insurance policy that is effective or issued on or after June 1, 2010, may offer an exchange subject to the following requirements:

(a) By or before May 31, 2011, on a one-time basis in writing, an issuer may offer to all of its existing Medicare supplement policyholders or certificateholders covered by a policy with an effective prior to June 1, 2010, the option to exchange the existing policy to a different policy that complies with subs. (4s), (5m) and (30m), as applicable.

(b) The offer shall be made on a nondiscriminatory basis without regard to the age or health status of the insured unless such offer or issue would be in violation of state or federal law.

(c) The offer shall remain open for a minimum of 120 days from the date of the mailing by the issuer.

(d) In the event of an exchange, if the replaced policy is priced on an issue age rate schedule, the rate charged to the insured for the newly exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured.

(e) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(f) The issuer may not apply new preexisting condition limitations or a new incontestability period to the newly issued policy for those benefits that were contained in the exchanged policy or certificate of the insured but may apply a preexisting condition limitation of no more than 6 months to any added benefits contained in the newly issued policy or certificate that were not present in the exchanged policy or certificate.

Ins 3.39 (36) GENETIC INFORMATION. In addition to compliance with ss. 631.89 and 632.748, Stats., beginning on May 21, 2009, an issuer of a Medicare supplement policy or certificate may not deny or condition the issuance or effectiveness of the policy or certificate, including the imposition of any exclusion of benefits under the policy based on a preexisting condition, on the basis of the genetic information with respect to such individual. The issuer may not discriminate in the pricing of the policy or certificate, including the adjustment of rates of an individual on the basis of the genetic information with respect to such individual.

(a) In this subsection and for use in policies or certificates:

1. "Family member" means, with respect to an individual, any other individual who is a first through fourth degree relative of the individual.

2. "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

3. "Genetic services" means a genetic test, genetic counseling including, obtaining, interpreting, or assessing genetic information, or genetic education.

4. "Genetic test" means an analysis of human deoxyribonucleic acid, ribonucleic acid or chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal

changes. The term “genetic test” does not mean an analysis of proteins or metabolites that does not detect genotypes, mutation, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

5. “Issuer of a Medicare supplement policy or certificate” includes third-party administrators, or other person acting for or on behalf of such issuer.

6. “Underwriting purposes,” means all of the following:

a. Rules for, or determinations of, eligibility including enrollment and continued eligibility for benefits under the policy.

b. The computation of premium or contribution amounts under the policy.

c. The application of any preexisting condition exclusions under the policy.

d. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(b) An issuer of a Medicare supplement policy or certificate may not request or require an individual or a family member of such individual to undergo a genetic test. An issuer may not request, require or purchase genetic information for use in underwriting. An issuer may not request, require or purchase genetic information with respect to any individual prior to such individual’s enrollment under the policy in connection with such enrollment.

(c) Nothing in par. (b) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from any of the following;

1. Denying or conditioning the issuance or effectiveness of a policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant.

2. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy.

(d) Notwithstanding par. (b), the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members to further increase the premium for the group.

(e) An issuer of a Medicare supplement policy or certificate may not request or require an individual or a family member of such individual to undergo a genetic test. Nothing in this paragraph shall be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a payment determination when consistent with the requirements of par. (b). If genetic information is obtained, the request may only include the minimum amount necessary to accomplish the intended purpose.

(f) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring or purchasing of other information concerning any individual, such request, requirement or purchase may not be considered a violation of this section.

SECTION 23. Section Ins 3.39 Appendix 1 (intro) is amended to read:

Ins 3.39 Appendix 1

~~The~~ For policies with an effective date prior to June 1, 2010 the following information shall be inserted prior to each outline of coverage provided to an insured and include the information specific to the plan type.

SECTION 24. Ins 3.39 Appendices 2 and 3 are repealed recreated to read:

Ins 3.39 Appendix 2

For policies with an effective date on or after June 1, 2010, the following information shall be inserted prior to each outline of coverage provided to an insured and include information specific to the plan type.

PREMIUM INFORMATION

We can only raise your premium if we raise the premium for all policies like yours in this state. [Include information specifying when premiums will change.]

If your policy was issued as an under age 65 policy due to disability, when you turn 65 premiums will remain at the disabled rates. [Include this statement within premium information when issuer does not change premium to age 65 rate.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY 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 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.

(1) The outline of coverage for a Medicare replacement insurance policy as defined in s. 600.03 (28p) (a) and (c), Stats., shall contain the following language: Medicare replacement insurance policy: This policy provides basic Medicare hospital and physician benefits. It also includes benefits beyond those provided by Medicare. This policy is a replacement for Medicare and is subject to certain limitations in choice of providers and area of service. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.

(2) (a) In 24–point type: For Medicare supplement policies marketed by intermediaries:

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

(b) In 24–point type: For Medicare supplement policies marketed by direct response:

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

(c) For Medicare replacement policies as defined in s. 600.03 (28p) a. and c., Stats.:

(insert company's name) has contracted with Medicare to provide Medicare benefits. Except for emergency care anywhere or urgently needed care when you are temporarily out of the service area, all services, including all Medicare services, must be provided or authorized by (insert company's name).

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

(b) For Medicare replacement policies, as defined in s. 600.03 (28p) a. and c., Stats., 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 reflect accurately 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.

The following information shall be inserted AFTER the specific plan type outline of coverage that is provided to all insureds. The information shall include the information specific to the plan type.

(4) All limitations and exclusions, including each of the following, must be listed under the caption "**LIMITATIONS AND EXCLUSIONS"** if benefits are not provided:

(a) Nursing home care costs beyond what is covered by Medicare and the additional 30–day skilled nursing mandated by s. 632.895 (3), Stats.

(b) Home health care above the number of visits covered by Medicare and the 365 visits mandated by s. 632.895 (2), Stats. [For Medicare select policies only.]

(c) Physician charges above Medicare's approved charge.

(d) Outpatient prescription drugs.

(e) Most care received outside of U.S.A.

(f) Dental care, dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids, unless eligible under Medicare.

(g) Coverage for emergency care anywhere or for care received outside the service area if this care is treated differently than other covered benefits.

(h) Waiting period for pre–existing conditions.

(i) Limitations on the choice of providers or the geographical area served (if applicable for Medicare select policies only).

(j) Usual, customary, and reasonable limitations.

(5) CONSPICUOUS STATEMENTS AS FOLLOWS:

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

(6) A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.

(7) Information on how to file a claim for services received from non–participating providers because of an emergency within or outside of the service area shall be prominently disclosed.

(8) If there are restrictions on the choice of providers, a list of providers available to enrollees shall be included with the outline of coverage.

(9) A description of the review and appeal procedure for denied claims.

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

MEDICARE SUPPLEMENT AND MEDICARE SELECT PREMIUM INFORMATION

Annual Premium

$ ( ) BASIC MEDICARE SUPPLEMENT OR MEDICARE SELECT COVERAGE

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT OR MEDICARE SELECT POLICY

Each of these riders may be purchased separately.

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

$ ( ) 1. 100% of the Medicare Part A hospital deductible

$ ( ) 2. 50% of the Medicare Part A hospital deductible per benefit period with no out-of-pocket maximum

$ ( ) 3. Additional home health care

An aggregate of 365 visits per year including those covered by Medicare

$ ( ) 4. 100% of Medicare Part B deductible

$ ( ) 5. 100% of the Medicare Part B medical deductible subject to copayment or coinsurance of no more than $20 per office visit and no more than $50 per emergency room visit in addition to the Medicare Part B deductible and in addition to out-of-pocket maximums.. The emergency room copayment or coinsurance fee shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

$ ( ) 6. Medicare Part B excess charges

Difference between the Medicare eligible charge and the amount charged by the provider which shall be no greater than the actual charge or the limited charge allowed by Medicare, whichever is less

$ ( ) 7. Foreign travel emergency 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. during the first 60 days of a trip with a lifetime 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. Medicare select policies and the Medicare Supplement 50% and 25% Cost-Sharing plans and Medicare Select 50% and 25% Cost-Sharing plans shall modify the outline to reflect the benefits that are contained in the policy or certificate and the optional or included riders.)

IN ADDITION TO THIS OUTLINE OF COVERAGE, [ISSUER] WILL SEND AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES THAT WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

(11) If premiums for each rating classification are not listed in the outline of coverage under subsection (10), then the issuer shall give a separate schedule of premiums for each rating classification with the outline of coverage.

(12) Include a summary of or reference to the coverage required by applicable statutes.

(13) The term “certificate” should be substituted for the word “policy” throughout the outline of coverage where appropriate.

Appendix 3

OUTLINE OF COVERAGE

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

(The designation and caption required by sub. (4s) (b) 4.)

MEDICARE SUPPLEMENT PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Note: This includes the Medicare deductibles for Part A and Part B, but does not include [the plan’s separate riders deductible.]

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $ [current deduct-Ible]	$0 or □ OPTIONAL PART A DEDUCTIBLE RIDER*	
	61st to 90th days	All but $ [current amount] per day	$ [current amount] per day	
	91st day and after while using 60 lifetime reserve days	All but $ [current amount] per day	$ [current amount] per day	
	Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses**	

	Beyond the additional 365_days	$0	$0	
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days 21st through 100th day 101st day and after	All approved amounts All but $ [current amount] per day $[0]	$0 Up to $[ ] a day $0	
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	
BLOOD	First 3 pints Additional amounts	$0 100%	First 3 pints $0	
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care	$0 or [ ]% of coinsurance or copayments	◊

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

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

MEDICARE SUPPLEMENT POLICIES - PART B BENEFITS

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	[AFTER YOU PAY A $ [ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES Eligible expense	First $[ ] of Medicare	$ 0	$0 or □ OPTIONAL PART B	

for physician's services, in-patient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	approved amounts* Remainder of Medicare approved amounts	 Generally 80%	DEDUCTIBLE RIDER** Generally 20% □ OPTIONAL MEDICARE PART B EXCESS CHARGES RIDER**	
BLOOD	First 3 pints Next $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs [$[ ] (Part B deductible)] 20%	
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	
HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	40 visits or □ OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER**	
[PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.]*	[First $120 each calendar year] [Additional charges]	[$0] [$0]	[$120] [$0] or $[dollar amount]	

*Once you have been billed [$] of Medicare approved amounts for covered services (that are noted with an asterisk), your Medicare Part B deductible will have been met for the calendar year.

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

SECTION 25. Ins 3.39 Appendices 4 through 8 are renumbered Appendices 6 through 10.

SECTION 26. Ins 3.39 Appendices 4 and 5 are created to read:

Ins 3.39 Appendix 4

OUTLINE OF COVERAGE

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT 50% and 25% COST-SHARING PLANS

(The designation required by sub. (5m) (g) 1. and (h) 1.)

You will pay [half or one quarter] the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[ ] each calendar year. The amounts that count toward your annual out-of-pocket limit are noted with diamonds (◊) in the chart below. Once you reach the annual out-of-pocket limit, the policy plays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE COST-SHARING PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	AFTER YOU PAY A $[ ] DEDUCTIBLE THIS POLICY PAYS	YOU PAY
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services	First 60 days	All but $ [current deduct-Ible]	$[ ] (50% or 75% of Medicare Part A deductible.)	◊
	61st to 90th days	All but $ [current amount]	$ [current amount] per day	

and supplies		per day		
	91st day and after while using 60 lifetime reserve days	All but $ [current amount] per day	$ [current amount] per day	
	Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses**	
	Beyond the additional 365 days	$0	$0	
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital	First 20 days	All approved amounts	$0	◊
	21st through 100th day	All but $ [current amount] per day	Up to $[ ] a day	
	101st day and after	$0	$0	
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	
BLOOD	First 3 pints	$0	[50% or 75%]	◊
	Additional amounts	100%	$0	
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services		All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care	[50% or 75%] of coinsurance or copayments	◊

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

MEDICARE COST-SHARING POLICIES - PART B BENEFITS

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	AFTER YOU PAY A $[ ] DEDUCTIBLE THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES. Eligible expense for physician's services, in-patient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $[ ] of Medicare approved amounts* Preventive Benefits for Medicare covered services. Remainder of Medicare approved amounts.	$ 0 Generally 75% or more of Medicare approved amounts. Generally 80%	$0 Remainder of Medicare approved amounts. Generally [10% or 15%]	◊ ◊
BLOOD	First 3 pints Next $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 Generally 80%	[50% or 75%] $0 Generally [10% or 15%]	◊ ◊ ◊
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	
HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	40 visits or □ OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER**	
[PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE	[First $120 each calendar year] [Additional charges]**	[$0] [$0]**	[$120] [$0] or $[dollar amount]**	

Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.]*				

*Once you have been billed [$] of Medicare approved amounts for covered services (that are noted with an asterisk), your Medicare Part B deductible will have been met for the calendar year.

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

Ins 3.39 Appendix 5

OUTLINE OF COVERAGE -

(COMPANY NAME)

OUTLINE OF MEDICARE SELECT INSURANCE AND MEDICARE SELECT 50% and 25% COST-SHARING PLANS

(The designation and caption required by sub. (30m) (i) 8. and 9., or the designation required by sub. (30m) (r) 1. and (s) 1.)

Note: Add the following text if the policy is a Medicare Select 50% or 25% Cost-Sharing Plan: You will pay [half or one quarter] the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[ ] each calendar year. The amounts that count toward your annual out-of-pocket limit are noted with diamonds (◊) in the chart below. Once you reach the annual limit, the policy plays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare approved amounts (these are called "Excess Charges"), and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE SELECT PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	AFTER YOU PAY A $ [ ] DEDUCTIBLE THIS POLICY PAYS	YOU PAY

HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days 61st to 90th days 91st day and after while using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but $ [current deduct-Ible] All but $ [current amount] per day All but $ [current amount] per day $0 $0	$0 or [ ]% of Medicare Part A deductible $ [current amount] per day $ [current amount] per day 100% of Medicare eligible expenses** $0	◊
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days 21st through 100th day 101st day and after	All approved amounts All but $ [current amount] per day $0	$0 Up to $[ ] a day $0	◊
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	
BLOOD	First 3 pints Additional amounts	$0 100%	[3 pints] or [ ]% $0	◊
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care	$0 or [ ]% of coinsurance or copayments	◊

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

MEDICARE SELECT POLICIES - PART B BENEFITS

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First $[ ] of Medicare approved amounts	$0	[$[ ] (Part B deductible)] or $0	◊
	[Preventive Benefits for Medicare covered services**]	[Generally [ ]% or more of Medicare approved amounts**]	[Remainder of Medicare approved amounts**]	
	Remainder of Medicare approved amounts	Generally 80%	Generally [10% or 15%]	◊
BLOOD	First 3 pints	$0	[ ]%	◊
	Next $ [ ] of Medicare approved amounts*	$0	$0	◊
	Remainder of Medicare approved amounts	Generally 80%	Generally [10% or 15%]	◊
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	
HOME HEALTH CARE		100% of charges for visits	365 visits for medically necessary services	

		considered medically necessary by Medicare		
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.*	[First $120 each calendar year] [Additional charges]**	[$0] [$0]**	[$120] [$0] or $[dollar amount]**	

*Once you have been billed [$] of Medicare approved amounts for covered services (that are noted with an asterisk), your Medicare Part B deductible will have been met for the calendar year.

** NOTE: Issuers should include in the outline of coverage the appropriate preventive benefit based upon whether or not the policy is a cost-sharing policy.

SECTION 27. Ins 3.39 Appendix 6 as renumbered is amended to read:

Ins 3.39 APPENDIX 4<u>6</u>

[NOTICE OF CHANGE FOR OUTLINE OF COVERAGE]

(COMPANY NAME)

NOTICE OF CHANGES IN MEDICARE AND YOUR [MEDICARE SUPPLEMENT OR MEDICARE REPLACEMENT] COVERAGE – 2_____

THE FOLLOWING CHART BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR [MEDICARE SUPPLEMENT OR MEDICARE REPLACEMENT] COVERAGE.

PLEASE READ THIS CAREFULLY!

[Note: A brief description of the revisions to Medicare Parts A and B with a parallel description of supplemental benefits with subsequent changes, including dollar amounts, provided by the Medicare supplement or Medicare replacement coverage in substantially the following format.]

SERVICES	**MEDICARE BENEFITS**		**YOUR [MEDICARE SUPPLEMENT OR MEDICARE REPLACEMENT] COVERAGE**	
	In 2____, Medicare Pays Per Benefit Period	**Effective January 1, 2____, Medicare will Pay**	**In 2____, Your Coverage Pays**	**Effective January 1, 2____, Your Coverage will Pay Per Calendar Year**
MEDICARE PART A SERVICES AND SUPPLIES				
HOSPITALIZATION	All but $___	All but $___ for		

Inpatient hospital services, semi-private room and board, misc. hospital services & supplies, such as drugs, x-rays, lab tests and operating room	for the first 60 days/benefit period All but $___ a day for 61st-90th days/benefit period All but $___ a day for 91st~~-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)~~ day and after while using 60 lifetime reserve days $0 ~~for additional 365 days~~once lifetime reserve days are used: Additional 365 days $0 ~~beyond additional 365 days.~~beyond the additional 365 days	the first 60 days/benefit period All but $___ a day for 61st-90th days/benefit period All but $___ a day for 91st~~-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)~~ $0 once lifetime reserve days are used: Additional 365 days $0 beyond the additional 365 days.		
SKILLED NURSING FACILITY CARE Skilled nursing care in a facility approved by Medicare.	First 20 days 100% of costs	First 20 days 100% of costs		

Confinement must meet Medicare standards. You must have been in a hospital for at least 3 days and enter the facility within 30 days after discharge.	All but $___ (current amount per day) for the 21st – 100th day $[0] of the 101st day and thereafter.	All but $___ (current amount per day) for the 21st – 100th day $[0] of the 101th day and thereafter.		
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	$0 for first 3 pints. 100% of additional amounts		
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care $0 or [ ]% of coinsurance or copayments	All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care $0 or [ ]% of coinsurance or copayments		◊
MEDICAL EXPENSES				
MEDICAL EXPENSES Eligible expense for physician's services, medical services in and out patient, physical and speech therapy, diagnostic tests, and durable medical equipment.	After $[ ] deductible, generally 80% of remainder of Medicare approved amounts	After $[ ] deductible, generally 80% of remainder of Medicare approved amounts		

HOME HEALTH CARE	100% of charges for visits considered medically necessary by Medicare		40 visits	
PREVENTIVE MEDICAL CARE BENEFIT Some annual physical and preventive tests and services administered or ordered by your doctor when NOT covered by Medicare	$0	$0	$120	

[Note: 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 SUMMARIZES THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT OR MEDICARE REPLACEMENT] COVERAGE PROVIDED BY (COMPANY) AND ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE CENTERS FOR MEDICARE & MEDICAID SERVICES. FOR INFORMATION ON YOUR [MEDICARE SUPPLEMENT OR MEDICARE REPLACEMENT] POLICY CONTACT:

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

SECTION 28. This section may be enforced under ss. 601.41, 601.64, 601.65, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

SECTION 29. EFFECTIVE DATE. These changes will take effect on the first day of the month after publication, as provided in s. 227.22(2)(intro.), Stats.

Dated at Madison, Wisconsin, this _____ day of March 2009.

_____
Sean Dilweg
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

for Section Ins 3.39 relating to Medicare supplement and replacement insurance

This rule change will have no significant effect on the private sector regulated by OCI.

FISCAL ESTIMATE WORKSHEET

Detailed Estimate of Annual Fiscal Effect

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 339**

Subject
Medicare supplement insurance

One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):
None

Annualized Costs:	Annualized Fiscal impact on State funds from: Increased Costs	Decreased Costs
A. State Costs by Category		
State Operations - Salaries and Fringes	**$ 0**	**$ -0**
(FTE Position Changes)	(**0** FTE)	(**-0** FTE)
State Operations - Other Costs	**0**	**-0**
Local Assistance	**0**	**-0**
Aids to Individuals or Organizations	**0**	**-0**
TOTAL State Costs by Category	**$ 0**	**$ -0**
B. State Costs by Source of Funds	**Increased Costs**	**Decreased Costs**
GPR	**$ 0**	**$ -0**
FED	**0**	**-0**
PRO/PRS	**0**	**-0**
SEG/SEG-S	**0**	**-0**
C. State Revenues Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, etc.)	**Increased Rev.**	**Decreased Rev.**
GPR Taxes	**$ 0**	**$ -0**
GPR Earned	**0**	**-0**
FED	**0**	**-0**
PRO/PRS	**0**	**-0**
SEG/SEG-S	**0**	**-0**
TOTAL State Revenues	**$ 0 None**	**$ -0 None**

NET ANNUALIZED FISCAL IMPACT

	STATE	LOCAL
NET CHANGE IN COSTS	$ **None 0**	$ **None 0**
NET CHANGE IN REVENUES	$ **None 0**	$ **None 0**

Prepared by:	Telephone No.	Agency
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)

Division of Executive Budget and Finance
DOA-2048 (R10/2000)

Wisconsin Department of Administration

FISCAL ESTIMATE

☒ ORIGINAL ☐ UPDATED

☐ CORRECTED ☐ SUPPLEMENTAL

LRB Number	Amendment No. if Applicable
Bill Number	Administrative Rule Number **INS 339**

Subject
Medicare supplement insurance

Fiscal Effect

State: ☒ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☒ No local government costs

1. ☐ Increase Costs
   ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs
   ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues
   ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues
   ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected:
   ☐ Towns ☐ Villages ☐ Cities
   ☐ Counties ☐ Others _____
   ☐ School Districts ☐ WTCS Districts

Fund Sources Affected
☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

Long-Range Fiscal Implications

None

Prepared by:	**Telephone No.**	**Agency**
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)