Clearinghouse Rule 08-112

STATE OF WISCONSIN **OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)**

★★★ NOTICE OF RULEMAKING HEARING ★★★

NOTICE IS HEREBY GIVEN that pursuant to the authority granted under s. 601.41(3), Stats., and the procedures set forth in under s. 227.18, Stats., OCI will hold a public hearing to consider the adoption of the attached proposed rulemaking order affecting Section Ins 3.39, Wis. Adm. Code, relating to Medicare supplement insurance.

HEARING INFORMATION

Date: January 27, 2009
Time: 1:00 p.m., or as soon thereafter as the matter may be reached
Place: OCI, Room 227, 125 South Webster St 2nd Floor, Madison, WI

Written comments can be mailed to:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins 339
Office of the Commissioner of Insurance
PO Box 7873
Madison WI 53707-7873

Written comments can be hand delivered to:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins 339
Office of the Commissioner of Insurance
125 South Webster St – 2nd Floor
Madison WI 53703-3474

Comments can be emailed to:

Julie E. Walsh
julie.walsh@wisconsin.gov

Comments submitted through the Wisconsin Administrative Rule Web site at: http://adminrules.wisconsin.gov on the proposed rule will be considered.

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

SUMMARY OF PROPOSED RULE & FISCAL ESTIMATE

For a summary of the rule see the analysis contained in the attached proposed rulemaking order. There will be no state or local government fiscal effect. The full text of the proposed changes, a summary of the changes and the fiscal estimate are attached to this Notice of Hearing.

INITIAL REGULATORY FLEXIBILITY ANALYSIS

NOTE If there is a fiscal effect on government the paragraph immediately preceding this section needs to be modified.

PICK 1 of the Following and fix to fit your rule:

This rule does not impose any additional requirements on small businesses.

If there is an effect on small business, the end of the relating clause must be "and affecting small business" and per 227.114(5) the notice letter must be sent to the "small business ombudsman" and the "Secretary of Commerce" and the following notice provided:

Notice is hereby further given that pursuant to s. 227.114, Stats., the proposed rule may have an effect on small businesses. The initial regulatory flexibility analysis is as follows:

a. Types of small businesses affected:
   Insurance agents, LSHO, Town Mutuals, Small Insurers, etc.
b. Description of reporting and bookkeeping procedures required:
   None beyond those currently required.
c. Description of professional skills required:
   None beyond those currently required.

If there may be significant economic impact on small business, send the notice letter to the "small business regulatory review board" & include the following:

Notice is hereby further given that pursuant to s. 227.138(2g), Stats., the proposed rule may have a significant economic impact on small businesses.

OCI SMALL BUSINESS REGULATORY COORDINATOR

The OCI small business coordinator is Eileen Mallow and may be reached at phone number (608) 266-7843 or at email address eileen.mallow@wisconsin.gov

CONTACT PERSON

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the OCI internet Web site at **http://oci.wi.gov/ocirules.htm** or by contacting Inger Williams, Public Information and Communications, OCI, at: inger.williams@wisconsin.gov, (608) 264-8110, 125 South Webster Street – 2nd Floor, Madison WI or PO Box 7873, Madison WI 53707-7873.

PROPOSED 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 Appendices 4 through 8;

To amend Ins 3.39 (1); (2) (q), (4) (intro.) (a) 3., 8., 17.; (5) (intro.) and (c) 4., 6., and 12.; (6) (intro.); (7) (a); (8) (c); (15); (24) (g); (30); Appendix 1;

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

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

Relating to Medicare supplement insurance and affecting small business.

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 ss. 628.34, and 628.38, Wis. Stats., authorize 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 110-223) and delegated the function of implementing the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Public Law 110-175). The GINA law requires states to adopt necessary changes by September 24, 2009 and to have regulations in place for MIPPA by June 1, 2010. 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 states insurance regulations, the NAIC Model Act. To date Wisconsin has passed several of Model Acts through statute and most frequently 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 and the NAIC requirements, to the extent necessary, and updates the appendices to reflect current requirements.

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, co-insurance 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 including the repeal of Appendices currently numbered 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 a waived state, the office 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 that has no out-of-pocket maximum limitation and will create a Medicare Part B 100% deductible with co-payment requirements for office and emergency room visits.

While the federal standardized plans eliminate the preventative health care coverage, the proposed rule retains those benefits. Also, although the standardized plans are first incorporating a hospice care benefit while the office has had such benefit for over 3 years and will retain the benefit into the June 1, 2010 benefits. The proposed rule includes a newly created paragraph to address insurers' 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 ss. 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 disclosures benefits, consumer rights and marketing practices. In furthering this oversight, the proposed rule includes specific reference to MIPPA that requires insurers that are marketing and selling insurance products to Wisconsin seniors enrolled in Medicare Advantage to fill in "gaps" that those products comply with the Medicare supplement 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 to 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, insurer'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 beneficiaries 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 insurers 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 insurers meet the definition of a small business under s. 227.114, Wis. Stats.

10. See the attached Private Sector Fiscal Analysis.

The proposed rule will not significantly impact the private sector. Insurers 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 insurers' ability to continue offering Medigap policies to Wisconsin consumers.

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. OCI maintains a database of all licensed insurers 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.

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
PO Box 7873
Madison WI 53707-7873

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Web site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

SECTION 1. Ins 3.39 (1) is amended to read:

(1) PURPOSE. (a) This section establishes requirements for health and other disability insurance policies primarily sold to Medicare eligible persons. Disclosure provisions are required for other disability policies sold to Medicare eligible person because such policies 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 intended to supplement Medicare and Medicare Advantage ~~supplement and Medicare replacement health insurance which is~~ 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.

(c) Further 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 must be compliant with this section, and pursuant to s. 104 (c) of Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), policies that are

advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare Advantage plans must comply with Medicare supplement requirements of s. 1882 (o) the federal Social Security Act (42 U.S.C. Section 1395 et. seq.).

SECTION 2. Ins 3.39 (3) (ce) and (cs) are created to read:

Ins 3.39 (3) DEFINITIONS. In this section and for use in policies or certificates:

(ce) "Balance bill" means seeking: to bill, charge, collect a deposit from; 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 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 3. Ins 3.39 (3) (q) and (4) (intro.) and (a) 3., 8. and 17., are amended to read:

Ins 3.39 (3) (q) "Medicare" shall be defined in the policy and 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.

Ins 3.39 (4) MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY AND CERTIFICATE REQUIREMENTS FOR POLICIES ISSUED OR EFFECTIVE 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 and prior to June 1, 2010, as a Medicare supplement policy or as a Medicare replacement policy, as defined in s. 600.03 (28p) (a) and (c), Stats., unless:

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

3.39 (4s) MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY AND CERTIFICATE REQUIREMENTS ISSUED OR EFFECTIVE 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, as defined in s. 600.03 (28p) (a) and (c), Stats., unless:

(a) The policy or certificate:

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

2. Discloses on the first page any applicable pre-existing conditions limitation, contains no pre-existing condition waiting period longer than 6 months and shall not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 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 shall not be cancelled or nonrenewed by the insurer on the grounds of deterioration of health. The policy may be cancelled only for nonpayment of premium or material misrepresentation. If the policy is issued by a health maintenance organization as defined by s. 609.01 (2), Stats., the policy may, in addition to the above reasons, be cancelled or nonrenewed by the 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 benefit period, if any, or payment of the maximum benefits. Receipt of the Medicare Part D benefits shall not be considered in determining a continuous loss.

7. Contains statements on the first page and elsewhere in the policy that satisfy the requirements of s. Ins 3.13 (2) (c), (d) or (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 greater of 3 months, the period for which the insured has paid the premium or the period specified in the policy).

8. Changes benefits automatically to coincide with and 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 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, printing 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 with a lower-case unspaced alphabet length not less than 120-point.

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.

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 effective date.

15. Provides for midterm cancellation at the request of the insured and that, if an insured cancels a policy midterm or the policy 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 pre-existing 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 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 has loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of the entitlement, as of the termination of the entitlement if the policyholder or certificateholder provides notice of loss of the entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of the entitlement.

20. Each Medicare supplement policy shall provide, and contain within the policy, that benefits and premiums under the policy shall be suspended for any period that may be provided by federal regulation, at the request of the policyholder if the policyholder is entitled to benefits under section 226 (b) of the Social Security Act and is covered under as 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 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. Shall not provide for any waiting period with respect to treatment of pre-existing 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. Shall not use an underwriting standard for under age 65 that is more restrictive than that used for 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, including ss. Ins 3.27 (5) (L), (9) (u), (v), (zh) 2. and 4.

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 carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued."

4. Contains in close conjunction on its first page the designation, printed in a distinctly contrasting color in 24-point type, and the caption, printed in a distinctly contrasting color 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 therefore, 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 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 statutory mandated provisions.

(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 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 form or certificate form:

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

2. Is submitted to the commissioner along with the policy form and is accompanied by rates and an actuarial demonstration that expected claims in relationship to premiums comply with the loss ratio standards in sub (16) (d). The policy form will not be approved unless the anticipated loss ratio along with the rates and actuarial demonstration show compliance.

(f) As regards subsequent rate changes to the policy form, the insurer:

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 that would violate sub (16) (d).

SECTION 5. Ins 3.39 (5) (intro.), (c) 4., 6., and 12., is amended to read:

Ins 3.39 (5) AUTHORIZED MEDICARE SUPPLEMENT POLICY AND CERTIFICATE DESIGNATION, CAPTIONS, REQUIRED COVERAGES, AND PERMISSIBLE ADDITIONAL BENEFITS FOR POLICIES ISSUED AND 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. A Medicare supplement policy or certificate shall include all of the following:

(c) 4. All 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, the copayment or coinsurance amount, including outpatient psychiatric care, subject to the Medicare Part B calendar year deductible;.

6. 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. 2. and payment of the Medicare Part A copayment or coinsurance for Medicare eligible skilled nursing care shall 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.;

12. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage for all Medicare Part A expenses for hospitalization not covered by Medicare for an additional 365 days to the extent the hospital is permitted to charge by federal

law and regulation and subject to the Medicare reimbursement rate and the provider shall not balance bill the insured;.

SECTION 6. 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 ISSUED OR EFFECTIVE 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 with an effective date on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as Medicare supplement policy or certificate unless it complies with these benefit standards. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the applicable requirements contained in par. (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. 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. Medicare Part A eligible expenses in a skilled nursing facility for the coinsurance or copayments from the 21st through the 100th day in a benefit period.

2. 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.

3. All Medicare Part A eligible expenses for hospice and respite care for the coinsurance or copayments.

4. All 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, the copayment or coinsurance amount, including outpatient psychiatric care, regardless of hospital confinement, subject to the Medicare Part B calendar year deductible.

5. Payment of 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.

6. 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. 2. and payment of the Medicare Part A copayment or coinsurance for Medicare eligible skilled nursing care shall 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.

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

8. Payment 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.

9. Coverage for the first 3 pints of blood payable under Part B.

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

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

12. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage for all Medicare Part A expenses for hospitalization not covered by Medicare to the extent the hospital is permitted to charge 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.

13. Payment 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.

14. 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. 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 (AMA CPT) codes, to a minimum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

15. Payment 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.

16. Payment 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 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 pre-existing limitation allowed in sub. (4s) (a) 2., and may consist of the following:

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

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

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

5. Coverage for 100% of the Medicare Part B medical deductible subject to co-payment or coinsurance of no more than $20 per office visit and no more than $50 per emergency room visit. The emergency room co-payment 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 CO-PAYMENT DEDUCTIBLE RIDER

6. Coverage for the difference between Medicare's 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 benefits obtained outside the United States. An issuer that offers this benefit shall 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 at least 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 high deductible plan only the following:

1. The designation: MEDICARE SUPPLEMENT INSURANCE - HIGH DEDUCTIBLE PLAN.

2. Coverage for 100% of the covered benefits described in pars. (d) and (e), after the insured has paid the calendar year deductible.

3. Benefits from the high deductible plan will not begin until out-of-pocket expenses exceed the set deductible. Out-of-pocket expenses for this deductible are expenses that would

ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the payment any deductible required of any selected riders.

4. The annual high deductible shall be [$1900] and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

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

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

2. Coverage for 100% of the Medicare Part A hospital co-payment or coinsurance 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 co-payment or coinsurance 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. Medicare Part A Deductible: 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. Skilled Nursing Facility Care: 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. Hospice Care: Coverage for 50% of cost sharing for all Part A Medicare 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 pays the Medicare Part B deductible until the out-of-pocket limitation is met as described under subd. 12.

10. Coverage for 100% of the cost sharing for the benefits described in pars. (d) 1., 5., 6., 8., 13., 15., and 16., and (e) 3., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder pays the Medicare Part A and Part B deductible and meets the out-of-pocket limitation described under subd. 12.

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

(i) 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 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 co-insurance 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. Medicare Part A Deductible: 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. Skilled Nursing Facility Care: 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. Hospice Care: Coverage for 75% of cost sharing for all Part A Medicare 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 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., 5., 6., 8., 13., 15, and 16., and (e) 3., to the extent the benefits do not duplicate benefits paid by

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

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

(j) For the Medicare supplement Basic Plus 50% Cost-Sharing plans offered, only the following:

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

2. Coverage for 100% of the Medicare Part A hospital coinsurance 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 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. Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period.

6. Skilled Nursing Facility Care: Coverage for 100% 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.

7. Hospice Care: Coverage for 100% of cost sharing for all Part A Medicare eligible expenses and respite care.

8. Coverage for 100%, 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.

9. Coverage for 100% of the cost sharing for the benefits described in pars. (d) 1., 5., 6., 8., 13., 15., and 16., and (e) 3., to the extent the benefits do not duplicate benefits paid by Medicare.

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

(6) USUAL, CUSTOMARY AND REASONABLE CHARGES. An issuer can only include a policy 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. (4) and shall contain all of the following required coverages, to be referred to as “Basic Medicare cost coverage” for a policy issued after January 1, 2005 and prior to June 1, 2010;

SECTION 8. Ins 3.39 (8) (c) is amended to read:

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

SECTION 9. Ins 3.39 (15) is amended to read:

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, 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 par. (15), [OCI form number], 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 10. Ins 3.39 (17) and (18) are created to read:

3.39 (17) NEW OR INNOVATIVE BENEFITS. An insurer 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 shall 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 shall not include an outpatient prescription drug benefit. New or innovative benefits shall 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 insurer offering any Medicare supplement plan shall be satisfied if all of the following are met:

1. The consent is obtained by telephonic or electronic enrollment by the insurer or group policyholder. A verification of the enrollment information must 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 insurer shall make available, upon request of the commissioner, records that demonstrate the insurer's ability to confirm enrollment and coverage.

SECTION 11. Ins 3.39 (24) (g) is amended to read:

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

SECTION 12. Section Ins 3.39 (30) is amended to read:

3.39 (30) (a) 1. This subsection shall apply to Medicare select policies and certificates issued on or 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:

(c) The commissioner may authorize an issuer to offer a Medicare select policy or certificate, pursuant to this subp. 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 shall not issue a Medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner.

(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~~subd. (i) of this ~~section~~par. and that the applicant understands the restrictions of the Medicare select policy or certificate.

SECTION 13. Ins 3.39 (30m), (35) and (36) are 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.

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.

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

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

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

a. Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of

operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual medical travel times within the community.

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

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

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

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

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

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

4. A description of the quality assurance program, including 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 unless specifically disapproved.

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

(g) A Medicare select policy or certificate shall not restrict payment for covered services provided by non-network providers if 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 for covered services that are not available through network providers.

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

1. An outline of coverage 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 with:

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

b. Other Medicare select policies or certificates.

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

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

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. (5m) (a).

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 describing how a grievance may be registered with the issuer.

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

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

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

6. The issuer shall report no later than each March 31st to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

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

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

2. For the purposes of subd. 1., a Medicare supplement policy or certificate 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.

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

2. For the purposes of subd. 1., a Medicare supplement policy or certificate 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. (q) or (r), a Medicare select policy shall contain the following benefits:

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

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

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

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

6. Coverage for the difference between Medicare Part B eligible charges and the actual charges for authorized referral services. This coverage shall not be described with words or terms that would lead insureds to believe the coverage is for Medicare part B Excess Charges as described in sub. (5m) (e) 6.

6. Coverage for benefits obtained outside of the United States as described in sub. (5m) (e) 7.

7. Coverage for preventive health care services as described in sub. (5m) (d) 14.

(q) The Medicare Select 50% Cost-Sharing plans offered on or after June 1, 2010, shall only contain the following:

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

2. Coverage for 100% of the Medicare Part A hospital coinsurance 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 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. Medicare Part A Deductible: 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. Skilled Nursing Facility Care: Coverage for 50% of the coinsurance 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. Hospice Care: 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 pays the Medicare Part B deductible until the out-of-pocket limitation is met as described under subd. 12.

10. Coverage for 100% of the cost sharing for the benefits described in sub. (5m) (d) 1., 5., 6., 8., 13., 15., and 16., and (e) 3., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder pays the Medicare Part A and Part B deductible and meets the out-of-pocket limitation described under subd. 12.

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

(r) The Medicare Select 25% Coverage Cost-Sharing plans shall only contain the following:

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

2. Coverage for 100% of the Medicare Part A hospital coinsurance 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 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. Medicare Part A Deductible: 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. Skilled Nursing Facility Care: Coverage for 75% of the coinsurance 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. Hospice Care: 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., 5., 6., 8., 13., 15., and 16., and (e) 3., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder pays the Medicare Part A and Part B deductible and meets the out-of-pocket limitation described under subd. 12.

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

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.

(s) A Medicare select policy 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 as separate riders or amendments, shall be priced separately and available for purchase separately.

(t) Insurers writing Medicare select policies shall additionally comply with subchs. I and III of ch. Ins 9.

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

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

2. 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.

3. The offer shall remain open for a minimum of 120 days from the date of the mailing by the insurer.

4. In the event of the 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.

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

6. The insurer may not apply new pre-existing 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 pre-existing 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 s. 632.748, Stats., beginning on May 21, 2009, an issuer of a Medicare supplement policy or certificate shall 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 pre-existing condition, on the basis of the genetic information with respect to such individual. The issuer shall 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) Definitions. In this subsection and for use in policies or certificates:

1. "Issuer of a Medicare supplement policy or certificate" includes third-party administrators, or other person action for or on behalf of such issuer.

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

3. "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.

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

5. "Genetic test" means an analysis of human DNA, RNA 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.

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 pre-existing 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 shall not request or require an individual or a family member of such individual to undergo a genetic test. An issuer shall not request, require or purchase genetic information for use in underwriting. An issuer shall 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 (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 the 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 and to further increase the premium for the group.

(e) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test. Nothing in this section 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 determinations 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 shall not be considered a violation.

SECTION 14. Section Ins 3.39 Appendix 1 (intro) is amended to read:

Ins 3.39 Appendix 1

[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 15. Ins 3.39 Appendices 2 and 3 are repealed.

SECTION 16. Ins 3.39 Appendix 2 and 3 as renumbered, are created to read:

Ins 3.39 Appendix 2

The following information shall be inserted at the beginning of each outline of coverage effective on or after June 1, 2010.

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 COST PREMIUM INFORMATION

Annual Premium

$ ( ) BASIC MEDICARE SUPPLEMENT OR MEDICARE COST COVERAGE

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT OR MEDICARE COST 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 co-payment or coinsurance of no more than $20 per office visit and no more than $50 per emergency room visit. The emergency room co-payment 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. beginning 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 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 WITH 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 (11), 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 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 deductible] All but $ [current amount] per day All but $ [current amount] per day $0 $0	$0 or □ OPTIONAL PART A DEDUCTIBLE RIDER* $ [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%	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 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 insurer 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 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*	$ 0	$0 or □ OPTIONAL PART B DEDUCTIBLE RIDER**	
	Remainder of Medicare approved amounts	Generally 80%	Generally 20% □ OPTIONAL MEDICARE PART B EXCESS CHARGES RIDER**	
BLOOD	First 3 pints	$0	All costs	
	Next $[ ] of Medicare approved amounts*	$0	[$[ ] (Part B deductible)]	
	Remainder of Medicare approved amounts	80%	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**	

*Once you have been billed [$] of Medicare approved amounts for covered services (which 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 17. Ins 3.39 Appendices 4 through 8 are renumbered Appendices 6 through 10.

SECTION 18. Ins 3.39 Appendices 4 and 5 as renumbered 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) (n) 1. and (o) 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 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 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 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 Beyond the additional 365_days	$0 $0	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%	[50% or 75%] $0	◊
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		Generally, most Medicare eligible expenses 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 insurer 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,	First $[ ] of Medicare approved amounts* Preventive Benefits for	$ 0 Generally 75% or more of Medicare	$0 Remainder of Medicare approved amounts.	◊

diagnostic tests, durable medical equipment.	Medicare covered services Remainder of Medicare approved amounts.	approved amounts Generally 80%	 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**	

*Once you have been billed [$] of Medicare approved amounts for covered services (which 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.

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 subs. (30m) (q) 1. and (r) 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 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 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 miscella-neous 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	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 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 for outpatient drugs and inpatient respite care	$0 or [ ]% of coinsurance or copayments	◊

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer 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 [Preventive Benefits for Medicare covered services**] Remainder of Medicare approved amounts	$0 [Generally [ ]% or more of Medicare approved amounts**] Generally 80%	[$[ ] (Part B deductible)] or $0 [Remainder of Medicare approved amounts**] Generally [10% or 15%]	◊ ◊
BLOOD	First 3 pints Next $ [ ] of Medicare	$0 $0	[ ]% $0	◊ ◊

	approved amounts* 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 considered medically necessary by Medicare	365 necessary visits for medically necessary services	
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 (which are noted with an asterisk), your Medicare Part B deductible will have been met for the calendar year.

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

SECTION 19. 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	**Effective January 1, 2____, Medicare will**	**In 2____, Your Coverage Pays**	**Effective January 1, 2____, Your**

	Period	Pay		Coverage will Pay Per Calendar Year
MEDICARE PART A SERVICES AND SUPPLIES				
HOSPITALIZATION Inpatient Hospital Services, Semi-Private Room & Board, Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room	All but $___ 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	All but $___ 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)~~ $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. 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.	First 20 days 100% of costs All but $___ (current amount per day) for the 21st - 100th day $[0] of the 101st day and thereafter.	First 20 days 100% of costs All but $___ (current amount per day) for the 21st - 100th day $[0] of the 101st 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	All but very limited	All but very limited		◊

Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	coinsurance for outpatient drugs and inpatient respite care $0 or [ ]% of coinsurance or copayments	coinsurance for outpatient drugs and inpatient respite care $0 or [ ]% of coinsurance or copayments		
MEDICAL PART B SERVICES AND SUPPLIES				
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) 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 20. 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 21. 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 December 2008.

_____

Sean Dilweg
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

for Section Ins 3.39 relating to Medicare supplement insurance

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

Division of Executive Budget and Finance
DOA-2047 (R10/2000)

Wisconsin Department of Administration

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:**	
A. State Costs by Category	**Increased Costs**	**Decreased Costs**
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)