(c) An issuer shall comply with section 1882 (c) (3) of the social security act, 42 U.S.C. 1395ss, by complying with all of the following:

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

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

3. Paying the participating physician or supplier directly.

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

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

6. Providing to the secretary, at least annually, a central mailing address to which all claims may be sent by Medicare issuers.

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

(d) 1. Except as provided in subd. 2., an issuer shall continue to make available for purchase any policy or certificate form issued after December 31, 2019, that has been approved by the commissioner. A policy or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

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

3. An issuer that discontinues the availability of a policy or certificate form pursuant to subd. 2., shall not file for approval a new policy or certificate form of the same type, as defined at subd. (3) (zar), as the discontinued form for a period of 5 years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

4. This subsection shall not apply to the riders permitted in sub. (5t) (e).

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

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

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

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

(g) Except as provided in par. (h), the experience of all policy or certificate forms of the same type, as defined in sub. (3) (zar), in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in sub. (31).

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

(i) No issuer may issue a Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy to an applicant 75 years of age or older, unless the applicant is subject to sub. (3r) or, prior to issuing coverage, the issuer either agrees not to rescind or void the policy or certificate except for intentional fraud in the application, or obtains one of the following:

1. A copy of a physical examination.
2. An assessment of functional capacity.
3. An attending physician's statement.
4. Copies of medical records.

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

(k) If an issuer nonrenews an insured who has a nonguaranteed renewable Medicare supplement policy or certificate with the issuer, the issuer shall at the time any notice of nonrenewal is sent to the insured, offer a currently available individual replacement Medicare supplement policy or certificate and those currently available riders resulting in coverage substantially similar to coverage provided by the replaced policy or certificate without underwriting. This replacement shall comply with sub. (27).

(L) For policies or certificates issued to persons newly eligible for Medicare on or after January 1, 2020, issuers shall combine the Wisconsin experience of all policy or certificate forms of the same type, as defined at sub. (3) (zar), for the purpose of calculating the loss ratio under sub. (16) (d), and rates. The rates for all policies or certificates of the same type shall be adjusted by the same percentage. If the Wisconsin experience is not credible, then national experience can be considered.

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

Section 59. INS 3.39 (15) is amended to read:

INS 3.39 (15) 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 policy or certificate, Medicare select policy or certificate, 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 policy or certificate, Medicare select policy or certificate, or Medicare cost policy ~~or certificate~~, each agent utilizing the advertisement shall file the advertisement with the commissioner ~~on a form specified by the commissioner~~ in the manner compliant with the commissioner's instructions. The advertisements shall comply with all applicable laws and rules of this state, including s. Ins 3.27 (9).

SECTION 60. INS 3.39 (15) (Note) is repealed.

SECTION 61. INS 3.39 (16) (a), (c), and (d) (intro.) and 1. are amended to read:

INS 3.39 (16) (a) Every issuer providing Medicare supplement or Medicare select ~~Medicare cost~~ coverage on a group or individual basis on policies or certificates ~~issued before or after August 1, 1992~~ in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of par. (d) when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

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

(d) (intro.) For purposes of subs. (4) (e), (4m) (e), (4t) (e), (14) (L), (14m) (L), (14t) (L) and this subsection, the loss ratio standards shall be:

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

SECTION 62. INS 3.39 (16) (d) 3. is renumbered INS 3.39 (16) (d) 3. (intro.) and amended to read:

INS 3.39 (16) (d) 3. For existing policies subject to this subsection, the loss ratio shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices. Incurred health care expenses when coverage is provided by a health maintenance organization may not include any of the following:

SECTION 63. INS 3.39 (16) (d) 3. a. to g. are created to read:

INS 3.39 (16) (d) 3. a. Home office and overhead costs.
b. Advertising costs.
c. Commissions and other acquisition costs.
d. Taxes.
e. Capital costs.
f. Administrative costs.
g. Claims processing costs.

SECTION 64. INS 3.39 (16) (e), and (17) are amended to read:

INS 3.39 (16) (e) An issuer may not use or change any premium rates for an individual or group Medicare supplement ~~or Medicare cost~~ policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and ~~approved~~ not disapproved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner and in accordance with ~~sub.~~ subs. (4) (g), (4m) (f), and (4t) (f) as applicable.

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

SECTION 65. INS 3.39 (21) (a) is amended to read:

INS 3.39 (21) (a) An issuer may provide and an agent or other representative may accept commission or other compensation for the sale of a Medicare supplement policy or certificate, or Medicare ~~cost~~ select policy or certificate only if the first year commission or other first year compensation is ~~at least 100% and no more than 150%~~ no more than 200% of the commission or other compensation paid for selling or servicing the policy or certificate in the 2nd year.

SECTION 66. INS 3.39 (21) (f) is created to read:

INS 3.39 (21) (f) No issuer may provide an agent or other representative commission or compensation for the sale of any other Medicare supplement policy or certificate, or Medicare select policy or certificate to an individual who is eligible for guaranteed issue under sub. (34), calculated on a different basis of the commissions paid for the sale of a Medicare supplement policy or certificate, or Medicare select policy or certificate to an individual who is eligible for open enrollment under sub. (3r).

SECTION 67. INS 3.39 (22) (d), (f) (intro.) and 1., (23) (a) (intro.), (c) and (e), and (24) (a) (intro.) and 3. are amended to read:

INS 3.39 (22) (d) If a Medicare supplement ~~or Medicare cost~~ policy or certificate, Medicare select policy or certificate contains any limitations with respect to ~~pre-existing~~ preexisting conditions, such limitations ~~shall~~ may appear on the first page~~.~~ or as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(f) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement, Medicare select, or Medicare cost ~~insurance~~ policies or certificates in the format similar to Appendix 4, Appendix 4m, or Appendix 4t. The notice shall contain all of the following:

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

(23) (a) Application forms for a Medicare supplement policy or certificate, a Medicare select policy or certificate, and a Medicare cost ~~coverage~~ policy shall comply with all relevant statutes and rules. The application form, or a supplementary form signed by the applicant and agent, shall include the following statements and questions:

(c) Upon determining that a sale will involve replacement, an issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement, Medicare select policy or certificate, or Medicare cost policy ~~or certificate~~, a notice regarding the replacement of ~~accident and sickness~~ Medicare supplement coverage in no less than 12 point type. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the solicitation of the policy the notice regarding replacement of ~~accident and sickness~~ Medicare supplement coverage.

(e) If the application contains questions regarding health and tobacco usage, include a statement that health questions should not be answered if the applicant is in the open-enrollment period described in sub. ~~(4m)~~(3r), or during a guaranteed issue period under sub. (34).

(24) (a) Every issuer marketing Medicare supplement insurance coverage in this state, directly or through its producers, shall do all of the following:

3. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or ~~enrollee~~ insured for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

SECTION 68. INS 3.39 (24) (a) 4. is created to read:

INS 3.39 (24) (a) 4. Display prominently by type-size, stamp or other appropriate means, on the first page of the policy the following: **"Notice to buyer: This policy may not cover all of your medical expenses."**

SECTION 69. INS 3.39 (25) (a), (b), and (c), and (26) (a) (intro.) and 1. are amended to read:

INS 3.39 (25) (a) In recommending the purchase or replacement of any Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare ~~replacement~~ cost policy ~~or certificate~~, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) Any sale of Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare ~~replacement~~ cost policy ~~or certificate~~ that will provide an individual more than one Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare ~~replacement~~ cost policy ~~or certificate~~ is prohibited.

(c) An agent shall forward each application taken for a Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare ~~replacement~~ cost policy to the issuer within 7 calendar days after taking the application. An agent shall mail the portion of any premium collected due the issuer to the issuer within 7 days after receiving the premium.

(26) (a) On or before March 1 of each year, every issuer providing Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost ~~insurance coverage~~ policy in this state shall report the following information for every individual resident of this state for which the insurer has in force more than one Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost ~~insurance~~ policy ~~or certificate~~:

1. Policy and certificate number~~, and~~.

SECTION 70. INS 3.39 (26) (a) 3. to 6. are created to read:

INS 3.39 (26) (a) 3. Type of policy.

4. Company name and national association of insurance commissioners number.

5. Name and contact information of person completing the form.

6. Other information as requested by the commissioner.

SECTION 71. INS 3.39 (26) (b), (27), (28) (title), (a) (intro.), (b) 2., and (c), (29) (a) and (b) 1., and (30) (a) are amended to read:

INS 3.39 (26) (b) The items in par. (a) must be grouped by individual policyholder or certificateholder and listed on a form ~~in substantially the same format as~~ made available by the commissioner. ~~Appendix 9~~ Issuers shall submit the information in the manner compliant with the commissioner's instructions on or before March 1 of each year.

(27) If a Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy ~~or certificate~~ replaces another Medicare supplement policy or certificate, Medicare select policy or certificate or Medicare cost policy ~~or certificate~~ that has been in effect for at least 6 months, the replacing issuer shall waive any time periods applicable to ~~pre-existing condition~~ preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement, Medicare select, or new Medicare cost policy for similar benefits to the extent such ~~time was~~ periods were satisfied under the original policy or certificate.

(28) Group ~~policy~~ certificate continuation and conversion requirements. **(a)** If a group Medicare supplement ~~insurance policy~~ certificate is terminated by the group ~~policyholder~~ issued a certificate and not replaced as provided in par. (c), the issuer shall offer certificateholders at least the following choices:

(b) 2. At the option of the group ~~policyholder~~ issued a certificate, offer the certificateholder continuations of coverage under the group ~~policy~~ certificate for the time specified in s. 632.897, Stats.

(c) If a group Medicare supplement ~~policy~~ certificate is replaced by another group Medicare supplement ~~policy~~ certificate, the issuer of the replacement ~~policy~~ certificate shall offer coverage to all persons covered under the old group ~~policy~~ certificate on its date of termination. Coverage under the new group ~~policy~~ certificate shall not result in any ~~limitation~~ exclusion for ~~pre-existing~~ preexisting conditions that would have been covered under the group ~~policy~~ certificate being replaced.

(29) Filing and approval requirements. **(a)** An issuer shall not deliver or issue for delivery a Medicare supplement policy or certificate, Medicare select policy or certificate or Medicare cost policy to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

(b) 1. Beginning January 1, 2007, issuers shall replace existing amended policies and riders for current and renewing ~~enrollees~~ insureds with filed and approved policy or certificate forms that are compliant with the MMA. An issuer shall, beginning January 1, 2007, use filed and approved policy or certificate forms that are compliant with the MMA for all new business.

(30) (a) 1. This subsection shall apply only to Medicare select policies and certificates issued to persons first eligible for Medicare prior to June 1, 2010. This subsection does not apply to Medicare supplement policies and certificates or Medicare cost policies.

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

SECTION 72. INS 3.39 (30) (b) is repealed.

SECTION 73. INS 3.39 (30) (k) (intro.), (n) (intro.), (q) 12., (r) 12., and (30m) (a) 1. are amended to read:

INS 3.39 (30) (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~~ The grievance procedures shall be aimed at mutual agreement for settlement ~~and~~, may include arbitration procedures, and may include all of the following~~.~~:

(n) Medicare select policies and certificates shall provide for continuation of coverage in the event the ~~Secretary~~ 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 federal program to be reauthorized under law or its substantial amendment.

(q) 12. Coverage of 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 $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the ~~Secretary~~ secretary.

(r) 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 $2,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the ~~Secretary~~ secretary.

(30m) (a) 1. This subsection shall only apply to Medicare select policies and certificates issued to persons first eligible for Medicare on or after June 1, 2010 and prior to January 1, 2020. This subsection does not apply to Medicare supplement policies or certificates.

SECTION 74. INS 3.39 (30m) (b) is repealed.

SECTION 75. INS 3.39 (30m) (i) 1. (intro.), and 8., (k) (intro.), (n) (intro.), (q) (intro.), (r) 12., and (s) 12. are amended to read:

INS 3.39 (30m) (i) 1. An outline of coverage in substantially the same format as Appendices ~~2~~2m and ~~5~~5m sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate to the following:

8. A designation: MEDICARE SELECT POLICY. This designation shall be immediately below and in the same type size as the designation required in sub. ~~(4s)~~(4m) (a) 10.

(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~~ The grievance procedures shall be aimed at mutual agreement for settlement ~~and~~, may include arbitration procedures, and include all of the following~~.~~:

(n) Medicare select policies and certificates shall provide for continuation of coverage in the event the ~~Secretary~~ 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 federal program to be reauthorized under law or its substantial amendment, then the following apply:

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

(r) 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~~ secretary.

(s) 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~~ secretary.

SECTION 76. INS 3.39 (30t) is created to read:

INS 3.39 (30t) Medicare select policies and certificates. **(a)** 1. This subsection shall apply only to Medicare select policies and certificates issued to persons newly eligible for Medicare on or after January 1, 2020. This subsection does not apply to Medicare supplement policies or certificates or to Medicare cost policies.

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

(c) The commissioner may authorize an issuer to offer a Medicare select policy or certificate, pursuant to this subsection OBRA, if the commissioner finds that the issuer has satisfied all of the requirements of this subsection.

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

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

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

c. That there are written agreements with network providers describing specific responsibilities.

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

e. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare select policy or certificate. This subd. 1. e. may not apply to supplemental charges, copayment, or coinsurance amounts as stated in the Medicare select policy or certificate.

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

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

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

a. The formal organizational structure.

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

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

d. The process to initiate corrective action when warranted.

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

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

7. Any other information requested by the commissioner.

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

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

(g) A Medicare select policy or certificate may not restrict payment for covered services provided by non-network providers if all 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 services described in subd. 1. through a network provider.

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

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

1. An outline of coverage in substantially the same format as Appendices 2t and 5t sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate to the following:

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

b. Other Medicare select policies or certificates.

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

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

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

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

6. A description of the policyholder's or certificate holder'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. (4t) (a) 10.

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

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

(k) A Medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from its subscribers for Wisconsin mandated benefits. These grievance procedures shall be aimed at mutual agreement for settlement, may include arbitration procedures, and may include all of the following:

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

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

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

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

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

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

(L) At the time of initial purchase of a Medicare select policy or certificate, a Medicare select issuer shall make available to each applicant for the 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, that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make Medicare select policies or certificates available without requiring evidence of insurability after the Medicare select policy or certificate has been in force for 6 months.

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

(n) Medicare select policies and certificates shall provide for continuation of coverage in the event the secretary determines that Medicare select policies and certificates issued under this section should be discontinued due to either the failure of the Medicare select program to be reauthorized under law or its substantial amendment, then all of the following apply:

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

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

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

(p) Except as provided in par. (r) or (s), a Medicare select policy or certificate issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, shall contain the following coverages:

1. The "basic Medicare supplement coverage" as described in sub. (5t) (d).

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

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

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

5. Coverage for emergency care obtained outside of the United States as described in sub. (5t) (e) 6.

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

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

2. Coverage for Medicare Part B copayment or coinsurance as described in sub. (5t) (e) 4.

(r) The Medicare Select 50% Cost-Sharing plans issued to persons who first became eligible for Medicare on or after January 1, 2020, shall only contain the following coverages:

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

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

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

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

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

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

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

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 as described in subd. 12. is met.

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

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

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

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

(s) The Medicare Select 25% Coverage Cost-Sharing plans issued to persons who first became eligible for Medicare on or after January 1, 2020, shall only contain all of the following phrases and coverages:

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

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

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

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

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

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

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

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 as described in subd. 12. is met.

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 as described in subd. 12. is met.

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

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

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

(t) A Medicare select policy or certificate may include permissible additional coverage as described in sub. (5t) (e) 2., 4., and 6. These riders, if offered, shall be added to the policy or certificate as separate riders or amendments and shall be priced separately and available for purchase separately.

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

SECTION 77. INS 3.39 (31) (a) and (b) is repealed and recreated to read:

INS 3.39 (31) (a) Every issuer providing individual or group Medicare supplement policies or certificates and every issuer providing individual or group Medicare select policies or certificates shall collect and file the following information with the commissioner. The data must be provided on a form made available by the commissioner. Issuers shall submit the following information in the manner compliant with the commissioner's instructions on or before May 31 of each year:

1. The actual experience loss ratio of incurred claims to earned premium net of refunds.

2. A credibility adjustment based on a creditability factor.

3. A comparison to the benchmark loss ratio that is a cumulative incurred claims divided by the cumulative earned premiums to date.

4. A calculation of the amount of refund or premium credit, if any.

5. A certification that the refund calculation is accurate.

(b) 1. For policies or certificates issued between December 31, 1980, and January 1, 1992, issuers shall combine the Wisconsin experience of all policy or certificate forms of the same type, as defined at sub. (3) (zar), for purposes of calculating the amount of refund or premium credit, if any. Issuers may combine the Wisconsin experience of all policies issued prior to January 1, 1981, with those issued between December 31, 1980, and January 1, 1992, if the issuer uses the 60% loss ratio for individual policies and the 70% loss ratio for group certificates renewed prior to January 1, 1996, and the appropriate loss ratios specified in sub. (16) (d), thereafter.

2. For policies or certificates issued on or after January 1, 1992, and prior to June 1, 2010, issuers shall combine the Wisconsin experience of all policy or certificate forms of the same type, as defined at sub. (3) (zar), for the purposes of calculating the amount of the refund or premium credit, if any, if the issuer uses the 65% loss ratio for individual policies and the 75% loss ratio for group certificates renewed on or after January 1, 1996 and prior to June 1, 2010, and the appropriate loss ratios specified in sub. (16) (d).

SECTION 78. INS 3.39 (31) (bm) is repealed.

SECTION 79. INS 3.39 (34) (a) 1., 2., (b) (intro.), 1s. and 2., (e) 4. and 5. are amended to read:

INS 3.39 (34) (a) 1. ~~Eligible persons~~ Persons eligible for guarantee issue are those individuals described in par. (b) who seek to enroll under the policy during the period specified in par. (c), and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy, Medicare select policy or Medicare cost policy, and where applicable, evidence of enrollment in Medicare Part D.

2. With respect to an eligible person, an issuer may not deny or condition the issuance or effectiveness of a Medicare supplement policy, Medicare select policy, or Medicare cost policy described in par. (e) that is offered and is available for issuance to new enrollees by the issuer, and shall not discriminate in the pricing of such a Medicare supplement, Medicare select, or Medicare cost policy because of health status, claims experience, receipt of health care, or medical condition and ~~shall not impose an exclusion of benefits based on condition and~~ shall not impose an exclusion of benefits based on a ~~pre-existing~~ preexisting condition under such a Medicare supplement policy, Medicare select policy, or Medicare cost policy.

(b) *Eligible persons.* An eligible person for guarantee issue is an individual described in any of the following subdivisions:

1s. The individual is enrolled in a Medicare select ~~plan~~ policy and is notified by the issuer, as required in par (f) 3. and s. Ins 9.35, as applicable, that a hospital is leaving the Medicare select policy network and that there is no other ~~participating~~ network provider hospital within a 30 minute or 30 mile radius of the policyholder.

2. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a ~~Program of All-Inclusive Care for the Elderly~~ (PACE) provider ~~under Section 1894 of the Social Security Act~~, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with ~~such~~ the PACE provider if ~~such~~ the individual were enrolled in a Medicare Advantage plan including any of the following:

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

5. Paragraph (b) 3., is a Medicare cost policy as described in sub. (7) ~~along~~ with any enhancements and riders, that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare cost policy.

SECTION 80. INS 3.39 (34) (ez) is renumbered INS 3.39 (34) (em) and amended to read:

INS 3.39 (34) (em) *Products ~~to which~~ that persons eligible for ~~Medicare persons are entitled~~ guarantee issue on or after June 1, 2010, and prior to January 1, 2020, are entitled to enroll into.* The Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy ~~or certificate to which~~ that the guarantee issue eligible persons are entitled to enroll include any of the following ~~under~~:

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

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

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

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

SECTION 81. INS 3.39 (34) (et) is created to read:

INS 3.39 (34) (et) *Products that persons eligible for guarantee issue are entitled to enroll into who first became eligible for Medicare on or after January 1, 2020.* The Medicare supplement policy or certificate, Medicare select policy or certificate, or Medicare cost policy that persons are entitled to enroll on the basis of guarantee issue includes any of the following:

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

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

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

4. Paragraph (b) 7., is a Medicare supplement policy or certificate as described in sub. (5t) with any riders available or a Medicare select policy or certificate as described in sub. (30t), that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy or certificate.

SECTION 82. INS 3.39 (34) (f) 1. and 2. are amended to read:

INS 3.39 (34) (f) *Notification provisions.* 1. At the time of an event described in par. (b) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies and certificates, Medicare select policies or certificates, or Medicare cost policies under par. (a). The notice shall be communicated within 10 working days of the issuer receiving notification of disenrollment.

2. At the time of an event described in par. (b) of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the (30) (k) the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies or certificates, Medicare select policies or certificates or Medicare cost polices under par. (a). ~~Such~~ The notice shall be communicated within 10 working days of the issuer receiving notification of disenrollment.

SECTION 83. INS 3.39 (35) (intro.) and (a) are amended to read:

INS 3.39 (35) Exchange of Medicare supplement policy. An issuer that submits and receives approval to offer a Medicare supplement ~~insurance~~ policy or certificate that is effective or issued to persons first eligible for Medicare on or after June 1, 2010, and before June 1, 2011, may offer an exchange subject to the following requirements:

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

SECTION 84. INS 3.39 Appendix 1 is amended to read:

SECTION 85. INS 3.39 Appendix 2 is renumbered INS 3.39 Appendix 2m and amended to read:

SECTION 86. INS 3.39 Appendix 2t is created to read:

SECTION 87. INS 3.39 Appendix 3 is renumbered INS 3.39 Appendix 3m and INS 3.39 Appendix 3m (title) and (subtitle), as renumbered, are amended to read:

SECTION 89. INS 3.39 Appendix 4 is renumbered INS 3.39 Appendix 4m and INS 3.39 Appendix 4m (title), as renumbered, is amended to read:

SECTION 90. INS 3.39 Appendix 4t is created to read:

SECTION 91. INS 3.39 Appendix 5 is renumbered INS 3.39 Appendix 5m and INS 3.39 Appendix 5m (title), as renumbered, is amended to read:

SECTION 92. INS 3.39 Appendix 5t is created to read:

SECTION 93. INS 3.39 Appendix 6 is amended to read:

SECTION 94. INS 3.39 Appendices 6m and 6t are created to read:

SECTION 95. INS 3.39 Appendix 7 is amended to read:

SECTION 96. INS 3.39 Appendices 8 and 9 are repealed.

SECTION 97. INS 3.55 (title), (1) and (2) are amended to read:

INS 3.55 (title) Benefit appeals under long-term care policies, life insurance-long-term care coverage ~~and Medicare replacement and supplement policies~~.

(1) Purpose. This section implements and interprets s. 632.84, Stats., for the purpose of establishing minimum requirements for the internal procedure for benefit appeals that insurers shall provide in long-term care policies, life insurance-long-term care coverage ~~and Medicare replacement or supplement policies~~. This section also facilitates the review by the commissioner of these policy forms.

(2) Scope. This section applies to individual and group nursing home insurance policies ~~and Medicare replacement or supplement policies~~ issued or renewed on or after August 1, 1988, and to long-term care policies and life insurance-long-term care coverage issued or renewed on and after June 1, 1991, except for polices or coverage exempt under s. Ins 3.455 (2) (b). This section does not apply to health maintenance organizations, limited service health organization or preferred provider plan, as those are defined in s. 609.01, Stats.

SECTION 98. INS 3.55 (3) (d) and (e) are repealed.

SECTION 99. INS 3.55 (4) (a) and (5) (intro.) are amended to read:

INS 3.55 (4) (a) Pursuant to s. 632.84 (2), Stats., an insurer shall include an internal procedure for benefit appeals in any long-term care policy~~,~~ or life insurance-long-term care coverage ~~any Medicare replacement cost or supplement policy an internal procedure for benefit appeals~~.

(5) Reports to the commissioner. An insurer offering a long-term care insurance policy or rider shall report to the commissioner by March 31 of each year a summary of all benefit appeals filed during the previous calendar year and the disposition of these appeals, including:

SECTION 100. INS 9.01 (3m) is amended to read:

INS 9.01 (3m) "Defined network plan" has the meaning provided under s. 609.01 (1b), Stats., and includes Medicare select policies~~, Medicare Select policy~~ and certificates as defined in s. Ins 3.39 ~~(30) (b) 4.~~ (3) (vm) and (ve), respectively, and health benefit plans that contract for use of participating providers.

SECTION 101. EFFECTIVE DATE. This rule is effective on the day of publication in the official state newspaper in accordance with s. 227.24 (2), Stats.

Dated at Madison, Wisconsin, this 10th day of October, 2019.

/s/Mark V. Afable
Commissioner

PUB: WSJ: October 15, 2019
#3772376 **WNAXLP**