Chapter Ins 3

CASUALTY INSURANCE

Ins 3.01 Accumulation benefit riders attached to health and accident policies (p. 71)
Ins 3.02 Automobile fleets, vehicles not included in (p. 72)
Ins 3.04 Dividends not deducted from premiums in computing loss reserves (p. 72)
Ins 3.08 Municipal bond insurance (p. 72)
Ins 3.09 Mortgage guaranty insurance (p. 75)
Ins 3.11 Multiple peril insurance contracts (p. 86)
Ins 3.13 Individual accident and sickness insurance (p. 87)
Ins 3.14 Group accident and sickness insurance (p. 93)
Ins 3.15 Blanket accident and sickness insurance (p. 94)
Ins 3.17 Reserves for accident and sickness insurance policies (p. 95)
Ins 3.18 Total consideration for accident and sickness insurance policies (p. 106)
Ins 3.19 Group accident and sickness insurance insuring debtors of a creditor (p. 106)
Ins 3.20 Substandard risk automobile physical damage insurance for financed vehicles (p. 106)
Ins 3.23 Franchise accident and sickness insurance (p. 107)
Ins 3.25 Credit life insurance and credit accident and sickness insurance (p. 107)
Ins 3.26 Unfair trade practices in credit life insurance and credit accident and sickness insurance (p. 130)
Ins 3.27 Advertisements of and deceptive practices in accident and sickness insurance (p. 130)
Ins 3.28 Solicitation, underwriting and claims practices in individual and franchise accident and sickness insurance (p. 150)
Ins 3.29 Replacement of accident and sickness insurance (p. 153)
Ins 3.30 Change of beneficiary and related provisions in accident and sickness insurance policies (p. 156)
Ins 3.31 Eligibility for and solicitation, underwriting and claims practices in group, blanket and group type accident and sickness insurance (p. 156)
Ins 3.32 Title insurance; prohibited practices (p. 161)
Ins 3.37 Transitional treatment arrangements (p. 164)
Ins 3.38 Coverage of newborn infants (p. 164-1)
Ins 3.39 Standards for disability insurance sold to the Medicare eligible (p. 165)
Ins 3.40 Coordination of benefits provisions in group and blanket disability insurance policies (p. 198)
Ins 3.41 Individual conversion policies (p. 212)
Ins 3.42 Plans of conversion coverage (p. 212)
Ins 3.43 High limit comprehensive plan of benefits (p. 213)
Ins 3.44 Effective date of s. 632.897, Stats. (p. 214)
Ins 3.45 Conversion policies by insurers offering group policies only (p. 215)
Ins 3.455 Long-term care, nursing home and home health care policies; loss ratios; continuation and conversion, reserves (p. 215)
Ins 3.46 Standards for long-term care, nursing home and home health care insurance and life insurance long-term care coverage. (p. 218)
Ins 3.47 Cancer insurance solicitation (p. 231)
Ins 3.48 Preferred provider plans (p. 235)
Ins 3.49 Wisconsin automobile insurance plan (p. 238)
Ins 3.50 Health maintenance organizations (p. 239)
Ins 3.51 Reports by individual practice associations (p. 255)
Ins 3.52 Limited service health organizations (p. 256)
Ins 3.53 HIV testing (p. 262)
Ins 3.54 Home health care benefits under disability insurance policies (p. 267)
Ins 3.55 Benefit appeals under long-term care policies, life insurance long-term care coverage and Medicare replacement or supplement policies (p. 269)
Ins 3.60 Disclosure of information on health care claim settlements (p. 271)

Ins 3.01 Accumulation benefit riders attached to health and accident policies. Except where such rider is used only on a policy replacing the company's own policy, and so recites, no rider providing for accumulations of benefits will be approved for use upon any policy of health and accident insurance, whether it is proposed to issue such rider with or without an additional premium. Such rider operates as an aid to twisting the policies

of another company in such manner as to make its use a direct encouragement of this practice.

Ins 3.02 Automobile fleets, vehicles not included in. Individually owned motor vehicles cannot be included or covered by fleet rates. The determining factor for inclusion under fleet coverage must be ownership and not management or use.

Ins 3.04 Dividends not deducted from premiums in computing loss reserves. Premiums returned to policyholders as dividends may not be deducted from the earned premiums in computing loss reserves under s. 623.04, Stats.

History: 1-2-56; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.08 Municipal bond insurance. (1) PURPOSE. This section implements and interprets ss. 601.42, 611.19 (1), 618.21, 623.03, 623.04, 627.05, 628.34 (2), 632.14, and 632.17, Stats., for the purpose of establishing minimum requirements for the transaction of a type of surety insurance known as municipal bond insurance.

(2) SCOPE. This section shall apply to the underwriting, marketing, rating, accounting and reserving activities of insurers which write municipal bond insurance.

(3) DEFINITIONS. (a) "Annual statement" means the fire and casualty annual statement form specified in s. Ins. 7.01 (5) (a).

(b) "Contingency reserve" means a reserve established for the protection of policyholders covered by policies insuring municipal bonds against the effect of excessive losses occurring during adverse economic cycles.

(c) "Cumulative net liability" means one-third of one percent of the insured unpaid principal and insured unpaid interest covered by in-force policies of municipal bond insurance.

(d) "Municipal bonds" means securities which are issued by or on behalf of or are paid or guaranteed by:

1. Any state, territory or possession of the United States of America;

2. Any political subdivision of any such state, territory or possession; or

3. Any agency, authority or corporate or other instrumentality of any one or more of the foregoing, or which are guaranteed by any of the foregoing.

(e) "Municipal bond insurance" means a type of surety insurance authorized by s. Ins 6.75 (2) (g) which is limited to the guaranteeing of the performance and obligations of municipal bonds.

(f) "Municipal bond insurer" means an insurer which issues municipal bond insurance.

(g) "Total net liability" means the average annual amount due, net of reinsurance, for principal and interest on the insured amount of any one issue of municipal bonds.

(h) "Person" means any individual, corporation for profit or not for profit, association, partnership or any other legal entity.

d. If applicable, the percentile used to determine usual, customary and reasonable charges.

e. The conditions and procedures under which a statistical data base is supplemented under sub. (4) (f).

2. The amount allowable under the insurer's guidelines for determination of the eligible amount of a provider's charge for a specific health care procedure or service in a given geographic area. The insurer is required to disclose the specific amount which is an allowable charge under the insurer's guidelines only if the provider's charge exceeds the allowable charge under the guidelines. The estimate may be in the form of a range of payment or maximum payment.

(b) Paragraph (a) does not require an insurer to disclose specifically enumerated proprietary information prohibited from disclosure by a contract between the insurer and the source of the data in the data base.

(c) A request under par. (a) may be oral or written. The insurer may require the insured to provide reasonably specific details, including the provider's estimated charge, and the C.P.T. or C.D.T. code, about the health care procedure or service before responding to the request. The response may be oral or written and the insurer shall respond within 5 working days after the date it receives a sufficient request. As part of the response, the insurer shall inform the requester of all of the following:

1. That the policy benefits are available only to individuals who are eligible for benefits at the time a health care procedure or service is provided.

2. That policy provisions including, but not limited to, preexisting condition and contestable clauses and medical necessity requirements, may cause the insurer to deny a claim.

3. That policy limitations including, but not limited to copayments and deductibles, may reduce the amount the insurer will pay for a health care procedure or service.

4. That a policy may contain exclusions from coverage for specified health care procedures or services.

(d) An insurer that provides a good faith estimate under par. (a) 2, based on the information provided at the time the estimate is requested, is not bound by the estimate.

(e) Upon request, an insurer shall provide the commissioner of insurance with information concerning the insurer's specific methodology.

(7) DISCLOSURE ACCOMPANYING PAYMENT. If an insurer, based on its specific methodology, determines that the eligible amount of a claim is less than the amount billed, the insurer shall disclose on the explanation of benefits or other document accompanying payment to the provider or the insured all of the following:

emerg r. + recr 6-17-93

(a) The C.D.T. code, C.P.T. code or other code acceptable to the commissioner of insurance and the date of service used in regard to each specific health care procedure or service for which the eligible amount is less than the amount billed.

(b) A telephone number of a contact person or section of the company from whom the provider or the insured may request the information specified under sub. (6) (a) 1.

(8) VIOLATION. A pattern of providing inaccurate or misleading responses under sub. (6) (c) is a violation of s. 628.34 (1) (a), Stats.

Note: Initial Applicability. This rule first applies to policies issued or renewed on or after May 1, 1993.

History: Cr. Register, December, 1992, No. 444, eff. 1-1-93; reprinted to correct copy in (4) (d), (6) (a) 2 and (c) (intro.), Register, February, 1993, No. 446.

Emerg. cr. Ins 3.65 + 3.651 eff. 6-17-93.