CR 88-183

STATE OF WISCONSIN)
)
OFFICE OF THE COMMISSIONER OF INSURANCE)

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Robert D. Haase, Commissioner of Insurance and custodian of the official records of said Office, do hereby certify that the annexed order creating a rule relating to internal benefit appeals procedures required under nursing home insurance policies in Medicare replacement or supplement policies was issued by this Office March 31, 1989.

I further certify that said copy has been compared by me with the original on file in this Office and that the same is a true copy thereof, and of the whole of such original.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name in the City of Madison, State of Wisconsin, this 31st day of March, 1989.

Robert D. Haase
Commissioner of Insurance

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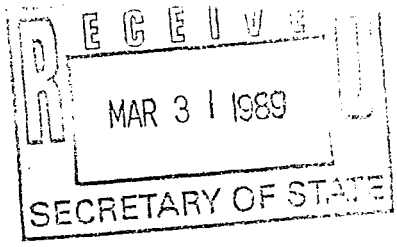

ORDER OF THE COMMISSIONER OF INSURANCE

CREATING A RULE

To create s. Ins 3.55 relating to internal benefit appeals procedures required under nursing home insurance policies and Medicare replacement or supplement policies.

ANALYSIS PREPARED BY THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3), and 631.20, Stats.

Statutes interpreted: ss. 631.20, and 632.84, Stats.

The purpose of this rule is to establish minimum standards relating to the internal benefit appeals procedures that must be provided under a nursing home insurance policy and a Medicare replacement or Medicare supplement policy. 1987 Wisconsin Act 156 requires that these policies include the internal benefit appeals procedure.

The 1987 Act requires that the appeals procedure be described in every policy, group certificate, and outline of coverage. The rule requires this description to include information on the insured's right to submit a request for review of any denial of a benefit, along with any supporting materials, and the insured's right to receive notification of the disposition

of the review within 30 days after the insurer receives receipt of the request for review.

The 1987 Act also requires that a written description of the appeals procedure be provided the insured when a benefit is denied. The rule requires that the written description include the name, address, and phone number of the individual designated by the insurer to be responsible for administering benefit appeals.

The rule requires insurers to retain benefit appeals records for at least 3 years from the date that the insurer reports the appeal to the commissioner. The rule further prohibits an insurer from establishing a time limit of under three years in which an insured may request a benefit appeal.

The 1987 Act further requires insurers to submit an annual report to the commissioner on all benefit appeals filed with and disposed of by the insurer. The rule requires that this report be filed with the commissioner on or before March 31 of each year; cover all benefit appeals filed during the previous calendar year; and include information on the name of the person designated by the insurer to be responsible for administering benefit appeals, changes to claims administration procedures by the insurer as a result of appeal reviews, the line of coverage involved in each appeal, the date on which each appeal is filed and disposed, the nature of each appeal, and a summary of the resolution of each appeal.

The rule defines a denial of a benefit as meaning the denial of a claim, the application of a limitation or exclusion clause, and the refusal to continue coverage.

SECTION 1. Ins 3.55 is created to read:

Ins 3.55 **BENEFIT APPEALS UNDER NURSING HOME INSURANCE POLICIES AND MEDICARE REPLACEMENT OR 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 nursing home insurance policies 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. This section does not apply to a health maintenance organization, limited service health organization, or preferred provider plan, as those are defined in s. 609.01, Stats.

(3) DEFINITIONS. In this section:

(a) "Benefit appeal" means a request for further consideration of actions involving the denial of a benefit.

(b) "Denial of a benefit" means any denial of a claim, the application of a limitation or exclusion provision, and any refusal to continue coverage.

(c) "Internal procedure" means the insurer's written procedure for handling benefit appeals.

(d) "Medicare replacement policy" has the meaning given in s. 600.03 (28p), Stats.

(e) "Medicare supplement policy" has the meaning given in s. 600.03 (28r), Stats.

(f) "Nursing home insurance policy" means a policy providing nursing home coverage under s. Ins 3.46.

(4) MINIMUM REQUIREMENTS. (a) Pursuant to s. 632.84 (2), Stats., an insurer shall include in any nursing home insurance policy and any Medicare replacement or supplement policy an internal procedure for benefit appeals.

(b) The insurer shall provide the policyholder and insured with a written description of the benefit appeals internal procedure at the time the insurer gives notice of the denial of a benefit. The written description shall include the name, address, and phone number of the individual designated by the insurer to be responsible for administering the benefit appeals internal procedure.

(c) An insurer shall describe the benefit appeals internal procedure in every policy, group certificate, and outline of coverage. The description shall include a statement on the following:

1. The insured's right to submit a written request in any form, including supporting material, for review by the insurer of the denial of a benefit under the policy; and

2. The insured's right to receive notification of the disposition of the review within 30 days of the insurer's receipt of the benefit appeal.

(d) An insurer shall retain records pertaining to a benefit appeal filed and the disposition of this appeal for at least 3 years from the date that the insurer files with the commissioner under sub. (5) the annual report in which information concerning the appeal is reported.

(e) No insurer may impose a time limit for filing a benefit appeal that is less than 3 years from the date the insurer gives notice of the denial of a benefit.

(f) An insurer shall make any internal procedure established pursuant to s. 632.84, Stats., available to the commissioner upon request and in as much detail as the commissioner requests.

(5) REPORTS TO THE COMMISSIONER. An insurer 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:

(a) The name of the individual designated by the insurer to be responsible for administering the benefit appeals internal procedure;

(b) Changes made in the administration of claims as a result of the review of benefit appeals;

(c) For each benefit appeal, the line of coverage;

(d) The date each benefit appeal was filed and, if within the calendar year, subsequently resolved;

(e) The date each benefit appeal carried over from the previous calendar year was resolved;

(f) The nature of each benefit appeal; and

(g) A summary of each benefit appeal resolution.

(6) POLICY DISAPPROVAL. The commissioner shall disapprove a policy under s. 631.20, Stats., if that policy does not meet the minimum requirements specified in this section.

EFFECTIVE DATE. Pursuant to s. 227.22 (2) (b), Stats., this rule shall first take effect on January 1, 1990.

Dated at Madison, Wisconsin, this 28th day of March, 1989.

Robert D. Haase
Commissioner of Insurance

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