Chapter Ins 3

CASUALTY INSURANCE

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.

(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.

History: Cr. Register, May, 1989, No. 401, eff. 1-1-90; am. (1), (2) and (4) (a), r. (3) (f), cr. (3) (cg) and (cm), Register, April, 1991, No. 424, eff. 6-1-91.

Ins 3.60 Disclosure of information on health care claim settlements. (1) PURPOSE. This section implements and interprets s. 628.34 (1) (a) and (12), Stats., for the purpose of allowing insureds and providers access to information on the methodology health insurers use to determine the eligible amount of a health insurance claim and permitting insureds to obtain estimates of amounts that their insurers will pay for specific health care procedures and services.

(2) DEFINITIONS. In this section:

(a) "C.D.T." means the American dental association's current dental terminology.

(b) "C.P.T." means the American medical association's current procedural terminology.

(c) "Provider" means a licensed health care professional.

(3) APPLICABILITY. (a) This section applies to an individual or group health insurance contract or certificate of individual coverage issued in this state that provides for settlement of claims based on a specific methodology, including but not limited to, usual, customary and reasonable charges or prevailing rate in the community, by which the insurer determines the eligible amount of a provider's charge.

(b) This section applies to a health maintenance organization to the extent that it makes claim settlement determinations for out-of-plan services as described in par. (a).

(4) DATA REQUIREMENTS. Any insurer that issues a policy or certificate subject to this section shall base its specific methodology on a data base that meets all of the following conditions:

(a) The fees in the data base shall accurately reflect the amounts charged by providers for health care procedures and services rather than amounts paid to or collected by providers, and may not include any medicare charges or discounted charges from preferred provider organization providers.

(b) The data base shall be capable of all of the following:

1. Compiling and sorting information for providers by C.D.T. code, C.P.T. code or other similar coding acceptable to the commissioner of insurance.

2. Compiling and sorting by zip code or other regional basis, so that charges may be based on the smallest geographic area that will generate a statistically credible claims distribution.

(c) The data base shall be updated at least every 6 months.

(d) No data in the data base shall be older than 18 months prior to the date the claim under consideration was received by the insurer.

(e) If the insurer uses an outside vendor's data base the insurer may supplement it with data from the insurer's own claim experience.

(f) An insurer may supplement a statistical data base with other information that establishes that providers accept as payment without balance billing amounts less than their initial or represented charge only if:

1. The insurer makes the disclosure required under sub. (6) (a) 1. e;

2. The information establishes that the provider generally and as a practice accepts the payment without balance billing regardless of which insurer is providing coverage; and

3. The information is no older than 18 months before the date of an update under par. (c), clearly establishes the practice, is documented and is maintained in the insurer's records during the period that the information is used and for 2 years after that date.

(5) DISCLOSURE REQUIREMENTS UPON ISSUANCE OF POLICY. (a) Each policy and certificate subject to this section shall include all of the following:

1. A clear statement, printed prominently on the first page of the policy or in the form of a sticker, letter or other form included with the policy, that the insurer settles claims based on a specific methodology and that the eligible amount of a claim, as determined by the specific methodology, may be less than the provider's billed charge. This subdivision does not apply to a closed panel health maintenance organization that does not provide coverage for nonemergency services by noncontracted providers.

2. If the policy or certificate includes a provision offering to defend the insured if a provider attempts to collect any amount in excess of that determined by the insurer's specific methodology, less coinsurance and deductibles, a clear statement that such a provision does not apply if the insured signs a separate agreement with the provider to pay any balance due.

(b) At the time a policy or certificate is issued, the insurer shall provide the policyholder or certificate holder with the telephone number of a contact person or section of the company that can furnish insureds with the information required to be disclosed under sub. (6).

(6) REQUESTS FOR DISCLOSURE. (a) Each insurer issuing a policy or certificate subject to this section shall, upon request, provide the insured with any of the following:

1. A description of the insurer's specific methodology including, but not limited to, the following:

a. The source of the data used, such as the insurer's claim experience, trade association's data, an expert panel of providers or other source.

b. How frequently the data base is updated.

c. The geographic area used in determining the eligible amount.

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. An estimate of the amount the insurer will pay for a specific health care procedure or service in a given geographic area. 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, 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:

(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.