CR 92-82

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

I, John W. Torgerson, Deputy Commissioner of Insurance and custodian of the official records of this office, certify that the attached is a corrected copy of a rule-making order affecting s. Ins 3.60, Wis. Adm. Code, relating to Data Collection and Disclosure of Information on Health Insurers' Claim Settlement Methodology and Estimates of Amounts to be Paid for Specific Health Care Procedures and Services, which was originally filed by this office on November 4, 1992, and refiled with corrections on November 19, 1992.

I further certify that I have compared this copy with the original on file in this office and that it is a true copy of the whole of the original.

Dated at Madison, Wisconsin, this 11th day of January, 1993.

John W. Torgerson
Deputy Commissioner

Attachment
35833T

ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

CREATING A RULE

To create Ins 3.60, relating to data collection and disclosure of information on health insurers' claim settlement methodology and estimates of amounts to be paid for specific health care procedures and services.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3) and 628.34 (12), Stats.

Statutes interpreted: s. 628.34 (12), Stats.

This rule requires insurers to provide their insureds and licensed health care professionals (providers) with certain information relating to payment of health insurance claims. A health care insurance policyholder or certificate holder may request that the insurer provide an estimate of the amount the insurer will pay for a specific procedure or service in a given geographical area and with information on how the insurer determines the eligible amount of a claim. The insurer must respond within 5 working days to a reasonably specific request from an insured and may require the insured to furnish the provider's estimated charge before responding to the request. Insurers must also furnish a requester with specified information on policy

provisions that may affect claim payments. Inquiries and responses may be oral or in writing. An insurer is not bound by a good faith estimate.

The rule applies to a health maintenance organization (HMO) only if it makes claim settlement determinations for out-of-plan services based on a specific methodology.

Each insurer that uses a specific methodology, such as usual, customary and reasonable charges or prevailing rate in the community, to determine eligible claim amounts must base that methodology on a data base which meets certain conditions specified in the proposed rule. Data bases must be updated at least every 6 months. Information on the specific methodology must be provided to an insured upon request, but an insurer need not disclose proprietary information if disclosure is prohibited by a contract between the insurer and the source of the data.

If an insurer pays less than the billed amount of a claim based on its specific methodology, it must furnish the insured or the provider with the medical or dental code it used for the procedure, the date of the service and a telephone number at the company which may be used to obtain further information, including information on the insurer's specific methodology, on the payment determination.

The rule also requires health insurers to disclose with each policy or certificate it issues that it settles claims based on a specific methodology and that a provider's bill may not be paid in full if the charge exceeds the amount determined by that methodology. Closed panel HMOs that do not provide coverage for nonemergency services by noncontracted providers are exempt from this requirement. If the policy or certificate includes a provision offering to defend the insured if a provider attempts to collect the balance of a bill in excess of the amount determined by the insurer's specific

methodology, the policy or certificate must inform the insured that this provision is inapplicable if the insured signs an agreement with the provider to pay any balance due. The insurer must also provide each insured, at the time a policy or certificate is issued, with the telephone number of a contact person or section of the company that can furnish the insured with further information on the methodology used and with payment estimates.

The rule also provides that a pattern of providing inaccurate or misleading estimates to insureds is an unfair marketing practice and may subject an insurer to administrative action, including the possibility of a forfeiture, by the office of the commissioner of insurance.

The rule will take effect on the first day of the month beginning after publication and it will first apply to policies and certificates issued on the first day of the 4th month after the effective date.

SECTION 1. Ins 3.60 is created to read:

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 at the time of an update under par. (c) may be older than 18 months.

(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. 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:

(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.

SECTION 2. INITIAL APPLICABILITY. This rule first applies to policies issued or renewed on the first day of the 4th month beginning after the effective date.

SECTION 3. EFFECTIVE DATE. This rule 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 11th day of January, 1993.

John W. Torgerson
Deputy Commissioner

772R8
01/11/93

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Robert D. Haase
Commissioner

121 East Wilson Street
P.O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-3585

January 11, 1993

MR GARY POULSON
DEPUTY REVISOR OF STATUTES
131 W WILSON ST STE 800
MADISON WI 53703-2233

RECEIVED
JAN 12 1993
Revisor of Statutes
Bureau

Re: Clearinghouse Rule No. 92-82
Section Ins 3.60, Wis. Adm. Code, Relating to Data Collection and Disclosure of Information on Health Insurers' Claim Settlement Methodology and Estimates of Amounts to be Paid for Specific Health Care Procedures and Services

Dear Mr. Poulson:

I am enclosing a copy of a second corrected draft of this administrative rule which has been filed with the Secretary of State. The first corrected copy filed on November 19, 1992, inadvertently omitted three provisions which were included in a germane modification submitted to the legislative committees, at the request of the assembly committee, during the review process. I am also enclosing a copy of the draft incorporating the missing language as it was submitted to the committees with that language highlighted.

I would greatly appreciate it if you will make these corrections in the rule as it appears in the Wisconsin Administrative Code.

Thank you very much for your assistance in this matter.

Sincerely,

John W. Torgerson
Deputy Commissioner

JWT:MAC:mle
Enclosures
2353Q

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Robert D. Haase
Commissioner

121 East Wilson Street
P.O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-3585

October 13, 1992

The Honorable Jerome Van Sistine
Chair, Committee on Tourism, Commerce,
Labor, Veterans' & Military Affairs
14 South, State Capitol
Madison, WI 53702

Re: Clearinghouse Rule 92-82; Germane Amendment

Dear Senator Van Sistine:

The Office of the Commissioner of Insurance submits the attached germane amendment to the above rule. If you have any questions regarding these changes, please contact me.

Sincerely yours,

Robert D. Haase
Commissioner of Insurance

RDH:FN:bm
1168b
Attachment

cc: Representative David Clarenbach
Chair, Assembly Special Committee
on Reform of Health Insurance

Mr. Gordon Anderson
Attorney, Wisconsin Legislative Council

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Robert D. Haase
Commissioner

121 East Wilson Street
P.O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-3585

October 13, 1992

The Honorable David Clarenbach
Chair, Assembly Special Committee
on Reform of Health Insurance
4 West, State Capitol
Madison, WI 53702

Re: Clearinghouse Rule 92-82; Germane Amendment

Dear Representative Clarenbach:

The Office of the Commissioner of Insurance submits the attached germane amendment to the above rule. If you have any questions regarding these changes, please contact me.

Sincerely yours,

Robert D. Haase
Commissioner of Insurance

RDH:FN:bm
1168b
Attachment

cc: Senator Jerome Van Sistine
Chair, Committee on Tourism, Commerce,
Labor, Veterans' & Military Affairs

Mr. Gordon Anderson
Attorney, Wisconsin Legislative Council

CHANGES SUBMITTED TO CLEARINGHOUSE RULE 92-82 AS GERMANE AMENDMENTS

The following revisions are included in the revised final draft rule submitted to the committee:

1. The revised rule adds s. Ins 3.60 (4) (e) which makes it clear that insurers may include in their database for determining usual and customary charges their own experience with provider charges in claims they have paid.

2. The revised rule adds s. Ins 3.60 (4) (f) which allows insurers to include in their database for determining usual and customary charges the amounts accepted by providers for a procedure without balance billing, even if the provider initially bills, or represents that it imposes, a higher charge. The insurer may include this data only if the insurer has and maintains documentation that the provider accepts the amount as a practice generally, not just for claims payable by the insurer, and the insurer discloses that it uses this type of data in its responses to requests for allowable charge information.

3. The revised rule changes s Ins 3.60 (6) (a) 2 to provide that an insurer need not disclose the specific amount which is an allowable charge under its usual and customary guidelines if the provider's charge for the intended procedure does not exceed the allowable charge.

4. The revised rule changes s Ins 3.60 (6) (c) to make it clear that the insurer may ask the insured to supply a code identifying the intended procedure when the insured asks for disclosure of effect of allowable charges guidelines under the rule.

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

CREATING A RULE

To create Ins 3.60, relating to data collection and disclosure of information on health insurers' claim settlement methodology and estimates of amounts to be paid for specific health care procedures and services.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3) and 628.34 (12), Stats.

Statutes interpreted: s. 628.34 (12), Stats.

This proposed rule requires insurers to provide their insureds and licensed health care professionals (providers) with certain information relating to payment of health insurance claims. A health care insurance policyholder or certificate holder may request that the insurer provide an estimate of the amount the insurer will pay for a specific procedure or service in a given geographical area and with information on how the insurer determines the eligible amount of a claim. The insurer must respond within 5 working days to a reasonably specific request from an insured and may require the insured to furnish the provider's estimated charge before

responding to the request. Insurers must also furnish a requester with specified information on policy provisions that may affect claim payments. Inquiries and responses may be oral or in writing. An insurer is not bound by a good faith estimate.

The proposed rule applies to a health maintenance organization (HMO) only if it makes claim settlement determinations for out-of-plan services based on a specific methodology.

Each insurer that uses a specific methodology, such as usual, customary and reasonable charges or prevailing rate in the community, to determine eligible claim amounts must base that methodology on a data base which meets certain conditions specified in the proposed rule. Data bases must be updated at least every 6 months. Information on the specific methodology must be provided to an insured upon request, but an insurer need not disclose proprietary information if disclosure is prohibited by a contract between the insurer and the source of the data.

If an insurer pays less than the billed amount of a claim based on its specific methodology, it must furnish the insured or the provider with the medical or dental code it used for the procedure, the date of the service and a telephone number at the company which may be used to obtain further information, including information on the insurer's specific methodology, on the payment determination.

The proposed rule also requires health insurers to disclose with each policy or certificate it issues that it settles claims based on a specific methodology and that a provider's bill may not be paid in full if the charge exceeds the amount determined by that methodology. Closed panel HMOs that do not provide coverage for nonemergency services by noncontracted providers are

exempt from this requirement. If the policy or certificate includes a provision offering to defend the insured if a provider attempts to collect the balance of a bill in excess of the amount determined by the insurer's specific methodology, the policy or certificate must inform the insured that this provision is inapplicable if the insured signs an agreement with the provider to pay any balance due. The insurer must also provide each insured, at the time a policy or certificate is issued, with the telephone number of a contact person or section of the company that can furnish the insured with further information on the methodology used and with payment estimates.

The proposed rule also provides that a pattern of providing inaccurate or misleading estimates to insureds is an unfair marketing practice and may subject an insurer to administrative action, including the possibility of a forfeiture, by the office of the commissioner of insurance.

The rule will take effect on the first day of the month beginning after publication and it will first apply to policies and certificates issued on the first day of the 4th month after the effective date.

SECTION 1. Ins 3.60 is created to read:

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 at the time of an update under par. (c) may be older than 18 months.

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

(f) An insurer may supplement a statistical database 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 two 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 attemps 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 database is supplemented under sub (4) (f).

2. The amount allowable under the insurer's quidelines for determination of 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 allowable charge for 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.

SECTION 2. INITIAL APPLICABILITY. This rule first applies to policies issued or renewed on the first day of the 4th month beginning after the effective date.

SECTION 3. EFFECTIVE DATE. This rule 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 _____ 1992.

_____
John W. Torgerson
Deputy Commissioner of Insurance

749R9
10/13/92

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

I, Robert D. Haase, Commissioner of Insurance and custodian of the official records of this office, certify that the attached is a corrected copy of a rule-making order affecting s. Ins 3.60, Wis. Adm. Code, relating to Data Collection and Disclosure of Information on Health Insurers' Claim Settlement Methodology and Estimates of Amounts to be Paid for Specific Health Care Procedures and Services, which was filed by this office on November 4, 1992.

I further certify that I have compared this copy with the original on file in this office and that it is a true copy of the whole of the original.

Dated at Madison, Wisconsin, this 19th day of November 1992.

Robert D. Haase
Commissioner of Insurance

Attachment
34786T

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CREATING A RULE

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The rule also requires health insurers to disclose with each policy or certificate it issues that it settles claims based on a specific methodology and that a provider's bill may not be paid in full if the charge exceeds the amount determined by that methodology. Closed panel HMOs that do not provide coverage for nonemergency services by noncontracted providers are exempt from this requirement. If the policy or certificate includes a provision offering to defend the insured if a provider attempts to collect the balance of a bill in excess of the amount determined by the insurer's specific

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(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 attemps 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.

SECTION 2. INITIAL APPLICABILITY. This rule first applies to policies issued or renewed on the first day of the 4th month beginning after the effective date.

SECTION 3. EFFECTIVE DATE. This rule 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 19th day of November 1992.

Robert D. Haase
Commissioner of Insurance

772R8
11/19/92

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Robert D. Haase
Commissioner

121 East Wilson Street
P.O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-3585

October 13, 1992

The Honorable Jerome Van Sistine
Chair, Committee on Tourism, Commerce,
Labor, Veterans' & Military Affairs
14 South, State Capitol
Madison, WI 53702

Re: Clearinghouse Rule 92-82; Germane Amendment

Dear Senator Van Sistine:

The Office of the Commissioner of Insurance submits the attached germane amendment to the above rule. If you have any questions regarding these changes, please contact me.

Sincerely yours,

Robert D. Haase
Commissioner of Insurance

RDH:FN:bm
1168b
Attachment

cc: Representative David Clarenbach
Chair, Assembly Special Committee
on Reform of Health Insurance

Mr. Gordon Anderson
Attorney, Wisconsin Legislative Council

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Robert D. Haase
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121 East Wilson Street
P.O. Box 7873
Madison, Wisconsin 53707-7873
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October 13, 1992

The Honorable David Clarenbach
Chair, Assembly Special Committee
on Reform of Health Insurance
4 West, State Capitol
Madison, WI 53702

Re: Clearinghouse Rule 92-82; Germane Amendment

Dear Representative Clarenbach:

The Office of the Commissioner of Insurance submits the attached germane amendment to the above rule. If you have any questions regarding these changes, please contact me.

Sincerely yours,

Robert D. Haase
Commissioner of Insurance

RDH:FN:bm
1168b
Attachment

cc: Senator Jerome Van Sistine
Chair, Committee on Tourism, Commerce,
Labor, Veterans' & Military Affairs

Mr. Gordon Anderson
Attorney, Wisconsin Legislative Council

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

CREATING A RULE

To create Ins 3.60, relating to data collection and disclosure of information on health insurers' claim settlement methodology and estimates of amounts to be paid for specific health care procedures and services.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3) and 628.34 (12), Stats.

Statutes interpreted: s. 628.34 (12), Stats.

This proposed rule requires insurers to provide their insureds and licensed health care professionals (providers) with certain information relating to payment of health insurance claims. A health care insurance policyholder or certificate holder may request that the insurer provide an estimate of the amount the insurer will pay for a specific procedure or service in a given geographical area and with information on how the insurer determines the eligible amount of a claim. The insurer must respond within 5 working days to a reasonably specific request from an insured and may require the insured to furnish the provider's estimated charge before

responding to the request. Insurers must also furnish a requester with specified information on policy provisions that may affect claim payments. Inquiries and responses may be oral or in writing. An insurer is not bound by a good faith estimate.

The proposed rule applies to a health maintenance organization (HMO) only if it makes claim settlement determinations for out-of-plan services based on a specific methodology.

Each insurer that uses a specific methodology, such as usual, customary and reasonable charges or prevailing rate in the community, to determine eligible claim amounts must base that methodology on a data base which meets certain conditions specified in the proposed rule. Data bases must be updated at least every 6 months. Information on the specific methodology must be provided to an insured upon request, but an insurer need not disclose proprietary information if disclosure is prohibited by a contract between the insurer and the source of the data.

If an insurer pays less than the billed amount of a claim based on its specific methodology, it must furnish the insured or the provider with the medical or dental code it used for the procedure, the date of the service and a telephone number at the company which may be used to obtain further information, including information on the insurer's specific methodology, on the payment determination.

The proposed rule also requires health insurers to disclose with each policy or certificate it issues that it settles claims based on a specific methodology and that a provider's bill may not be paid in full if the charge exceeds the amount determined by that methodology. Closed panel HMOs that do not provide coverage for nonemergency services by noncontracted providers are

exempt from this requirement. If the policy or certificate includes a provision offering to defend the insured if a provider attempts to collect the balance of a bill in excess of the amount determined by the insurer's specific methodology, the policy or certificate must inform the insured that this provision is inapplicable if the insured signs an agreement with the provider to pay any balance due. The insurer must also provide each insured, at the time a policy or certificate is issued, with the telephone number of a contact person or section of the company that can furnish the insured with further information on the methodology used and with payment estimates.

The proposed rule also provides that a pattern of providing inaccurate or misleading estimates to insureds is an unfair marketing practice and may subject an insurer to administrative action, including the possibility of a forfeiture, by the office of the commissioner of insurance.

The rule will take effect on the first day of the month beginning after publication and it will first apply to policies and certificates issued on the first day of the 4th month after the effective date.

SECTION 1. Ins 3.60 is created to read:

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 at the time of an update under par. (c) may be older than 18 months.

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

(f) An insurer may supplement a statistical database 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 two 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 attemps 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 database is supplemented under sub (4) (f).

2. The amount allowable under the insurer's quidelines for determination of 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 allowable charge for 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.

SECTION 2. INITIAL APPLICABILITY. This rule first applies to policies issued or renewed on the first day of the 4th month beginning after the effective date.

SECTION 3. EFFECTIVE DATE. This rule 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 _____ 1992.

_____

John W. Torgerson
Deputy Commissioner of Insurance

749R9
10/13/92

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Robert D. Haase
Commissioner

121 East Wilson Street
P.O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-3585

November 20, 1992

MR GARY POULSON
ASSISTANT REVISOR OF STATUTES
119 MARTIN LUTHER KING JR BLVD
MADISON WI 53702

RECEIVED
NOV 19 1992
Revisor of Statutes
Bureau

Re: Clearinghouse Rule No. 92-82
Section Ins 3.60, Wis. Adm. Code, Relating to Data Collection and Disclosure of Information on Health Insurers' Claim Settlement Methodology and Estimates of Amounts to be Paid for Specific Health Care Procedures and Services

Dear Mr. Poulson:

I am enclosing a copy of a corrected copy of this administrative rule which has been filed with the Secretary of State. The copy originally filed inadvertently omitted s. Ins 3.60 (6) (a) 1. e, Wis. Adm. Code, which was part of a germane modification submitted to the legislative committees, at the request of the assembly committee, during the review process. I am also enclosing a copy of the draft incorporating the missing language as it was submitted to the committees.

I would greatly appreciate it if you will make the correction in the rule that will be printed in the December 1992 Administrative Register.

Thank you very much for your assistance in this matter.

Sincerely yours,

Robert D. Haase
Commissioner of Insurance

RDH:imk
Enclosures
2292Q

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

I, Robert D. Haase, Commissioner of Insurance and custodian of the official records of this office, certify that the attached rule-making order affecting s. Ins 3.60, Wis. Adm. Code, relating to Data Collection and Disclosure of Information on Health Insurer's Claim Settlement Methodology and Estimates of Amounts to be Paid for Specific Health Care Procedures and Services, was issued by this office on November 4, 1992.

I further certify that I have compared this copy with the original on file in this office and that it is a true copy of the whole of the original.

Dated at Madison, Wisconsin, this 4th day of November 1992.

Robert D. Haase
Commissioner of Insurance

86431

1-1-93

ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

CREATING A RULE

To create Ins 3.60, relating to data collection and disclosure of information on health insurers' claim settlement methodology and estimates of amounts to be paid for specific health care procedures and services.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3) and 628.34 (12), Stats.

Statutes interpreted: s. 628.34 (12), Stats.

This rule requires insurers to provide their insureds and licensed health care professionals (providers) with certain information relating to payment of health insurance claims. A health care insurance policyholder or certificate holder may request that the insurer provide an estimate of the amount the insurer will pay for a specific procedure or service in a given geographical area and with information on how the insurer determines the eligible amount of a claim. The insurer must respond within 5 working days to a reasonably specific request from an insured and may require the insured to furnish the provider's estimated charge before responding to the request. Insurers must also furnish a requester with specified information on policy

provisions that may affect claim payments. Inquiries and responses may be oral or in writing. An insurer is not bound by a good faith estimate.

The rule applies to a health maintenance organization (HMO) only if it makes claim settlement determinations for out-of-plan services based on a specific methodology.

Each insurer that uses a specific methodology, such as usual, customary and reasonable charges or prevailing rate in the community, to determine eligible claim amounts must base that methodology on a data base which meets certain conditions specified in the proposed rule. Data bases must be updated at least every 6 months. Information on the specific methodology must be provided to an insured upon request, but an insurer need not disclose proprietary information if disclosure is prohibited by a contract between the insurer and the source of the data.

If an insurer pays less than the billed amount of a claim based on its specific methodology, it must furnish the insured or the provider with the medical or dental code it used for the procedure, the date of the service and a telephone number at the company which may be used to obtain further information, including information on the insurer's specific methodology, on the payment determination.

The rule also requires health insurers to disclose with each policy or certificate it issues that it settles claims based on a specific methodology and that a provider's bill may not be paid in full if the charge exceeds the amount determined by that methodology. Closed panel HMOs that do not provide coverage for nonemergency services by noncontracted providers are exempt from this requirement. If the policy or certificate includes a provision offering to defend the insured if a provider attempts to collect the balance of a bill in excess of the amount determined by the insurer's specific

methodology, the policy or certificate must inform the insured that this provision is inapplicable if the insured signs an agreement with the provider to pay any balance due. The insurer must also provide each insured, at the time a policy or certificate is issued, with the telephone number of a contact person or section of the company that can furnish the insured with further information on the methodology used and with payment estimates.

The rule also provides that a pattern of providing inaccurate or misleading estimates to insureds is an unfair marketing practice and may subject an insurer to administrative action, including the possibility of a forfeiture, by the office of the commissioner of insurance.

The rule will take effect on the first day of the month beginning after publication and it will first apply to policies and certificates issued on the first day of the 4th month after the effective date.

SECTION 1. Ins 3.60 is created to read:

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 attemps 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.

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.

SECTION 2. INITIAL APPLICABILITY. This rule first applies to policies issued or renewed on the first day of the 4th month beginning after the effective date.

SECTION 3. EFFECTIVE DATE. This rule 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 4th day of November 1992.

Robert D. Haase
Commissioner of Insurance

772R8
11/03/92