1987 Assembly Bill 387

Date of enactment: **March 17, 1988**
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1987 Wisconsin Act 156

AN ACT *to create* 632.84 of the statutes, *relating to* review and appeal procedures under a medicare supplement policy, medicare replacement policy or a nursing home insurance policy.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

PREFATORY NOTE: This bill requires each insurer offering a medicare supplement policy, medicare replacement policy or a nursing home insurance policy to establish an internal review and appeal procedure available to the policyholder and the insured or his or her representative upon denial of any benefits under the policy. In addition, the bill directs the insurer to communicate the procedure to the policyholder and insured at the time of denial of benefits.

The bill does not apply to health maintenance organizations, limited service health organizations or preferred provider plans, which are required by current law to establish a grievance procedure for enrolled participants.

SECTION 1. 632.84 of the statutes is created to read:

632.84 Benefit appeals under nursing home insurance and medicare replacement and supplement policies. (1) DEFINITIONS. In this section:

(a) "Nursing home" has the meaning given in s. 50.01 (3).

(b) "Nursing home insurance policy" means an individual or group insurance policy which provides coverage primarily for confinement or care in a nursing home.

(2) REVIEW AND APPEAL. (a) Except as provided in sub. (3), an insurer offering a medicare supplement policy, medicare replacement policy or nursing home insurance policy shall establish an internal procedure by which the policyholder and the insured or a representative of the policyholder or the insured may appeal the denial of any benefits under the medicare supplement policy, medicare replacement policy or nursing home insurance policy. The procedure established under this paragraph shall include all of the following:

1. The opportunity for the policyholder and insured or a representative of the policyholder or insured to submit a written request, which may be in any form and which may include supporting material, for review by the insurer of the denial of any benefits under the policy.

2. Within 30 days after receiving the request under subd. 1, disposition of the review and notification to the person submitting the request of the results of the review.

(b) An insurer shall describe the procedure established under par. (a) in every policy, group certificate and outline of coverage issued in connection with a medicare supplement policy, medicare replacement policy or nursing home insurance policy.

(c) If an insurer denies any benefits under a medicare supplement policy, medicare replacement policy or nursing home insurance policy, the insurer shall, at the time the insurer gives notice of the denial of any benefits, provide the policyholder and insured with a written description of the appeal process established under par. (a).

(d) An insurer offering a medicare supplement policy, medicare replacement policy or nursing home insurance policy shall annually report to the commissioner a summary of all appeals filed under this section and the disposition of those appeals.

(3) This section does not apply to a health maintenance organization, limited service health organization or preferred provider plan, as defined in s. 609.01.

SECTION 2. **Initial applicability.** This act first applies to medicare supplement policies, medicare replacement policies and nursing home insurance policies and riders to those policies which are issued or renewed on the first day of the 4th month beginning after the effective date of this SECTION.