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.

(i) "Policyholders' surplus" means an insurer's net worth, the difference between its assets and liabilities, as reported in its annual statement.

(4) MINIMUM CAPITAL OR PERMANENT SURPLUS. The minimum capital or permanent surplus of a municipal bond insurer shall be $2 million for an insurer first authorized to do business in Wisconsin on or before Janu-

1. A pre-existence defense;

2. A waiting period, such as for pregnancy, surgery or other stated condition or procedure;

3. A benefit maximum; or

4. Other policy limitation.

(5) EFFECTIVE DATE. This rule shall apply to all solicitation, underwriting, and claims activities relating to Wisconsin residents after December 1, 1974, except that sub. (3) (a) 4. a. and b. shall apply to coverage issued after said date and sub. (3) (a) 3. d., e. and g. shall apply to such activities after February 1, 1975.

History: Cr. Register, November, 1974, No. 227, eff. 12-1-74; emerg. am. (1), (2), (3) (intro.) and (c) and (4), eff. 6-22-76; am. (1), (2), (3) (intro.) and (c) and (4), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) and (2), Register, March, 1979, No. 279, eff. 4-1-79; am. (1), (2), (3) (intro.), (3) (a) 3. d., f. and 4. b., (3) (c) and (4), r. and recr. (3) (a) 3. c., (3) (b) 1. and 3., (4) (b) 1. and 3., Register, April, 1982, No. 316, eff. 5-1-82.

Ins 3.32 Title insurance; prohibited practices. (1) PURPOSE. This rule implements and interprets s. 601.01 (3) and ch. 628, Stats., for the purpose of prohibiting unfair practices in the transaction of the business of title insurance.

(2) SCOPE. This section applies to all title insurers and title insurance agents.

(3) DEFINITIONS. In this section:

(a) "Affiliate" has the meaning provided under s. 600.03 (1), Stats.

(am) "Agent" has the meaning provided under s. 600.03 (ir), Stats.

(b) "Affiliate producer" means an affiliate of a producer of title insurance, but only for the 12-month period commencing after June 30, 1987, and after the end of any quarter calendar year in which the affiliate's gross revenue from operation in this state from title insurance directly or indirectly referred by affiliated producers of title insurance exceeds 40% of the affiliate's gross revenue from operations in this state for title insurance in the previous quarter calendar year. However, if the previous quarter calendar year commences prior to July 1, 1988, the percentage is 80%; and if it commences prior to July 1, 1989, the percentage is 60%. "Affiliate producer" does not include a person who is affiliated with producers of title insurance who are all attorneys if the affiliate examines the title for each title insurance policy it issues.

(bm) "Control" has the meaning provided under s. 600.03 (13), Stats.

(c) "Producer of title insurance" means any of the following, other than a title insurer, who order or influence, directly or indirectly, the ordering of title insurance and related services:

1. Any owner or prospective owner of real or personal property or any interest therein;

2. Any lender or prospective lender in a transaction involving an obligation secured or to be secured either in whole or in part by real or personal property or any interest therein; and

3. Any agent, representative, attorney or employe of any owner or prospective owner or of any lender or prospective lender.

4. An affiliate producer.

(cm) "Supplementary rate information" has the meaning provided under s. 625.02 (3), Stats.

(d) "Title insurance rates" means all charges made by a title insurer in connection with the issuance of a title insurance policy or a commitment to issue a title insurance policy and includes, but is not limited to, search and examination charges.

(e) "Title insurer" means all insurance companies authorized to write title insurance as defined by section Ins 6.75 (2) (h) and their affiliates, and includes all officers, employes and representatives of the insurance companies or their affiliates.

(4) PROHIBITED PRACTICES. No title insurer or agent of a title insurer may engage in any of the following practices:

(a) Charging an amount for a title insurance policy or commitment for a title insurance policy other than the amount developed by application of the apropriate title insurance rate developed from the rates and supplementary rate information on file with the commissioner for use by the title insurer.

(b) Waiving, or offering to waive, all or any part of the applicable title insurance rate or premium developed by proper application of the appropriate title insurance rate developed from the rates and supplementary rate information on file with the commissioner.

(c) Charging a reduced title insurance rate under a so-called "take-off" or subdivision policy when the property involved is ineligible for such reduced rate.

(d) Charging a reduced title insurance rate under a so-called "take-off" or subdivision policy when such rate is not applicable in the particular transaction because the volume required to qualify for such reduced rate includes ineligible property.

(e) Paying or offering to pay the cancellation fee, the fee for a preliminary title report or other fee on behalf of any producer of title insurance after inducing the person to cancel an order with another title insurer.

(f) Making or guaranteeing, or offering to make or guarantee, directly or indirectly, any loan to any producer of title insurance regardless of the terms of the note or guarantee. This prohibition is not applicable to customary business collection procedures, claims settlement and salvage activities and other business activities totally unrelated to the solicitation of business for which a charge is made.

(g) Providing or offering to provide, directly or indirectly, a "compensating balance" or deposit in a lending institution either for the express or implied purpose of influencing the extension of credit by the lending institution to any producer of title insurance, or for the express or implied purpose of influencing the placement or channeling of title insurance business by the lending institution. This paragraph does not prohibit the maintenance by a title insurer or agent of demand deposits or

escrow deposits which are reasonably necessary for use in the ordinary course of the business of the title insurer or agent.

(h) Paying or offering to pay the fees or charges of an outside professional, including but not limited to, an attorney, engineer, appraiser, or surveyor, whose services are required by any producer of title insurance to structure or complete a particular transaction.

(i) Paying or offering to pay all or part of the salary of an employe of a producer of title insurance.

(j) Paying or offering to pay a fee to a producer of title insurance for services unless the fee bears a reasonable relation to the services performed. After June 30, 1987, for the purpose of this paragraph, a payment determined by applying a percentage amount or formula to the premium paid for title insurance is presumed, unless rebutted, not to bear a reasonable relation to services performed.

(k) Paying or offering to pay for services by a producer of title insurance if the services are required to be performed by the person in his or her capacity as a real estate or mortgage broker or salesperson or agent.

(l) Furnishing or offering to furnish, or paying or offering to pay for, furniture, office supplies, telephones, equipment or automobiles to a producer of title insurance, or paying for, or offering to pay for, any portion of the cost of renting, leasing, operating or maintaining any of these items. Marketing and title insurance promotional items clearly of an advertising nature of token or nominal value, or supplies such as title insurance application blanks and related forms are prohibited under this paragraph if they are made available to all producers of title insurance on the same terms and conditions.

(m) Paying for, furnishing, or waiving, or offering to pay for, furnish, or waive, all or any part of the rent for space occupied by a producer of title insurance.

(n) Renting or offering to rent space from a producer of title insurance, at a rent which is excessive when compared with rents for comparable space in the geographic area, or paying or offering to pay, rent based in whole or in part on the volume of business generated by a producer of title insurance except for a bona fide percentage lease based on the total volume of receipts of the title insurer when the services of that title insurer are offered from that location to the public generally.

(o) Paying or offering to pay for gifts, vacations, business trips, convention expenses, travel expenses, membership fees, registration fees, lodging or meals on behalf of a producer of title insurance, directly or indirectly, or supplying letters of credit, credit cards or any such benefits. This paragraph does not preclude reasonable, moderate and customary business entertainment and trade association activities and expense incurred and recorded by the title insurer or agent in the course of marketing its products and services.

(p) Paying or offering to pay money, prizes or other things of value to, or on behalf of, a producer of title insurance in a contest or promotional endeavor. This paragraph does not apply to offers or payments to trade associations or charitable or other functions where the thing of value is a contribution or donation rather than a business solicitation.

(q) Paying or offering to pay for advertising concerning the title insurer or agent in material distributed or promoted by a producer of title insurance, unless the payment is reasonable compensation for the advertising, is not greater than the amount charged for comparable advertising and any title insurer is permitted to advertise in the material on the same terms and conditions.

(r) Paying for or furnishing, or offering to pay for or furnish any brochures, billboards, or advertisements of a producer of title insurance, products or services appearing in newspapers, on the radio, or on television, or other advertising or promotional material published or distributed by, or on behalf of, a producer of title insurance.

(5) REFERRAL OF TITLE INSURANCE APPLICATIONS. For the purpose of sub. (3) (b) and s. Ins 6.61 (2m), an application or order for title insurance is presumed to be referred to an agent by an affiliate producer of title insurance if the affiliated producer of title insurance acts as a broker, agent, lender, representative or attorney in the transaction which results in the application or order and the application was not referred to the affiliate producer by an unaffiliated producer of title insurance.

History: Cr. Register, December, 1975, No. 240, eff. 1-1-76; emerg. am. (1), (2) and (3) (a), eff. 6-22-76; am. (1) (2), (3) (a) and (4) (o), Register, September, 1976, No. 249, eff. 10-1-76; am. (2) and (3) (a), Register, March, 1979, No. 279, eff. 4-1-79; am. (2), (3) (c) (intro.), (d), (4) (intro.), (e) to (p) and (r), renum. (3) (a) and (e) to be (3) (e) and (cm) and am., cr. (3) (intro.), (a), (am), (bm) and (c) 4., r. and recr. (3) (b), (4) (q) and (5), Register, November, 1986, No. 371, eff. 12-1-86.

Ins 3.38 Coverage of newborn infants. (1) PURPOSE. This section is intended to interpret and implement s. 632.91, Stats.

(2) INTERPRETATION AND IMPLEMENTATION. (a) Coverage of each newborn infant is required under a disability insurance policy if 1. the policy provides coverage for another family member, in addition to the insured person, such as the insured's spouse or a child, and 2. the policy specifically indicates that children of the insured person are eligible for coverage under the policy.

(b) Coverage is required under any type of disability insurance policy as described in par. (a), including not only policies providing hospital, surgical or medical expense benefits, but also all other types of policies described in par. (a), including accident only and short term policies.

(c) The benefits to be provided are those provided by the policy and payable, under the stated conditions except for waiting periods, for children covered or eligible for coverage under the policy.

(d) Benefits are required from the moment of birth for covered occurrences, losses, services or expenses which result from an injury or sickness condition, including congenital defects and birth abnormalities of the newborn infant to the extent that such covered occurrences, losses, services or expenses would not have been necessary for the routine postnatal care of the newborn child in the absence of such injury or sickness. In addition, under a policy providing coverage for hospital confinement and/or in-hospital doctor's charges, hospital confinement from birth continuing beyond what would otherwise be required for a healthy baby (e.g. 5 days) as certified by the attending physician to be medically necessary will be considered as resulting from a sickness condition.

(e) If a disability insurance policy provides coverage for routine examinations and immunizations, such coverage is required for covered children from the moment of birth.

(f) An insurer may underwrite a newborn, applying the underwriting standards normally used with the disability insurance policy form involved, and charge a substandard premium, if necessary, based upon such underwriting standards and the substandard rating plan applicable to such policy form. The insurer shall not refuse initial coverage for the newborn if the applicable premium, if any, is paid as required by s. 632.91 (3), Stats. Renewal coverage for a newborn shall not be refused except under a policy which permits individual termination of coverage and only as such policy's provisions permit.

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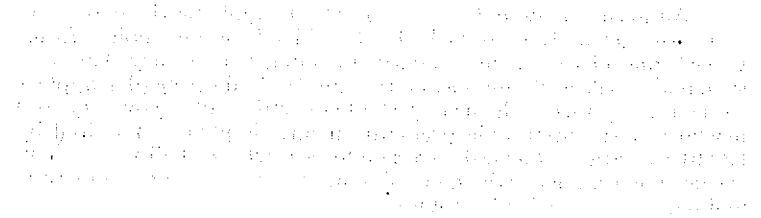

(b) Clear disclosure of any provision which limits benefits or access to service in the exclusions, limitations, and exceptions sections of the policy or certificate. Among the exclusions, limitations and exceptions which shall be disclosed are those relating to emergency and urgent care, restrictions on the selection of primary or referral providers, restrictions on changing providers during the contract period, out-of-pocket costs including copayments and deductibles, charges for missed appointments or other administrative sanctions, restrictions on access to care if copayments or other charges are not paid, and any restrictions on coverage for dependents who do not reside in the service area.

(c) Clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders.

(10) GRIEVANCE PROCEDURE. (a) Each health maintenance organization shall develop an internal grievance procedure which shall be described in each policy and certificate issued to enrollees. Policies and certificates shall include a definition of a grievance.

(b) In addition to the notice requirement under par. (a), each time the health maintenance organization denies a claim or initiates disenrollment proceedings, the health maintenance organization shall notify the affected enrollee of the right to file a grievance and the procedure to follow.

(c) The health maintenance organization shall acknowledge a grievance within 10 days of receiving it.

(d) The health maintenance organization shall retain records of all grievances for 3 years and shall develop a summary each year which shall include the date each grievance was filed, the nature of the grievance, the date of the resolution of the grievance, a summary of the resolution of the grievance, and a comment concerning any administrative changes made as a result of the grievance. This summary shall be filed with the commissioner by February 1 each year for the preceding year.

(11) OTHER NOTICE REQUIREMENTS. (a) Prior to enrolling members, the health maintenance organization shall provide to prospective group or individual policyholders information on the plan, including information on the services covered, a definition of emergency and out-of-area coverage, names and specific location of providers for each type of service, the cost of the plan, enrollment procedures, and limitations on benefits including limitations on choice of providers and the geographical area serviced by the organization.

(b) If a health maintenance organization terminates its relationship with any clinic or medical group it shall notify all subscribers who receive primary health care services from that clinic or medical group at least 30 days in advance of such termination. The health maintenance organization shall notify all subscribers in a geographical area served by the plan of any changes in it affiliations with providers which have a substantial effect on the availability of covered services in the area.

(12) DISENROLLMENT. (a) The health maintenance organization shall clearly disclose in the policy and certificate any circumstances under which the health maintenance organization may disenroll an enrollee.

(b) Except as provided in s. 632.897, Stats., the health maintenance organization may disenroll an enrollee from the health maintenance organization for the following reasons only:

1. The enrollee has failed to pay required premiums by the end of the grace period.

2. The enrollee has committed acts of physical or verbal abuse which pose a threat to providers or other members of the organization.

3. The enrollee has allowed a nonmember to use the health maintenance organization's certification card to obtain services or has knowingly provided fraudulent information in applying for coverage.

4. The enrollee has moved outside of the geographical service area of the organization.

5. The enrollee is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care. Disenrollment of an enrollee for this reason shall be permitted only if the health maintenance organization can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care physician, made a reasonable effort to assist the enrollee in establishing a satisfactory patient-physician relationship and informed the enrollee that he or she may file a grievance on this matter.

(c) The health maintenance organization may not disenroll an enrollee under par. (b) for reasons related to the physical or mental condition of the enrollee or for any of the following reasons:

1. Failure of the enrollee to follow a prescribed course of treatment.

2. Administrative actions such as failure to keep an appointment.

(d) A health maintenance organization which has disenrolled an enrollee for any reason except failure to pay required premiums shall make arrangements to provide similar alternate insurance coverage to enrollees. In the case of group certificate holders, this insurance coverage shall be continued until the person finds his or her own coverage or until the next opportunity to change insurers, whichever comes first. In the case of an enrollee covered on an individual basis, coverage shall be continued until the anniversary date of the policy or for one year, whichever is earlier.

(13) TIME PERIOD. In accordance with s. 227.116, Stats., the commissioner shall review and make a determination on an application for a certificate of authority within 60 business days after it has been received.

History: Cr. Register, June, 1986, No. 366, eff. 9-29-86.

Ins 3.51 Limited service health organizations. (1) PURPOSE. This section establishes financial and other standards for limited service health organizations doing business in Wisconsin. The requirements in this section are in addition to any other statutory or administrative rule requirements which apply to limited service health organizations.

(2) SCOPE. Except for subs. (4) and (8), this section applies to all limited service health organizations doing business in Wisconsin. Subsection (4) and (8) do not apply to a limited service health organization operated

as a line of business of a licensed insurer unless the insurer does substantially all of its business as a limited service health organization.

(3) DEFINITIONS. (a) "Acceptable letter of credit" means a clean, unconditional, irrevocable letter of credit issued by a Wisconsin bank or any other financial institution acceptable to the commissioner which renews on an annual basis for a 3-year term unless written notice of nonrenewal is given to the commissioner and the limited service health organization at least 60 days prior to the renewal date.

(b) "Limited service health organization" means a health care plan as defined in s. 609.01 (3), Stats.

(4) FINANCIAL REQUIREMENTS. (a) *Minimum capital or permanent surplus.* The minimum capital or permanent surplus requirement for a limited service health organization shall be not less than $75,000.

(b) *Security deposit.* 1. Each limited service health organization shall maintain either a deposit of securities with the state treasurer or an acceptable letter of credit on file with the commissioner's office. The amount of the deposit or letter of credit shall be not less than $75,000 for limited service health organizations. The letter of credit shall be payable to the commissioner whenever rehabilitation or liquidation proceedings are initiated against the limited service health organization.

2. The commissioner may accept the deposit or letter of credit under subd. 1. to satisfy the minimum capital or permanent surplus requirement under par. (a), if the limited service health organization demonstrates to the satisfaction of the commissioner that it does not retain any risk of financial loss because all risk of loss has been transferred to providers through provider agreements.

(c) *Compulsory surplus.* 1. Each limited service health organization shall maintain a compulsory surplus to provide security against contingencies that affect its financial position but which are not fully covered by provider contracts, insolvency insurance, reinsurance, or other forms of financial guarantees. The compulsory surplus is equal to not less than the greater of:

a. 3% of the premiums earned by the limited service health organization in the previous 12 months; or

b. $75,000.

2. The commissioner may accept the deposit or letter of credit under par. (b) to satisfy the compulsory surplus requirement if the limited service health organization demonstrates to the satisfaction of the commissioner that it does not retain any risk of financial loss because all risk of loss has been transferred to providers through provider agreements. The commissioner may, by order, require a higher or lower compulsory surplus or may establish additional factors for determining the amount of compulsory surplus required for a particular limited service health organization.

(d) *Security surplus.* The limited service health organization should maintain a security surplus to provide an ample margin of safety and clearly assure a sound operation. The security surplus of a limited service health organization shall be equal to not less than 110% of compulsory surplus.

(e) *Operating funds.* The limited service health organization shall make arrangements, satisfactory to the commissioner, to provide sufficient funds to finance any operating deficits in the business and to prevent impairment of the insurer's initial capital or permanent surplus or its compulsory surplus. To determine the acceptability of these arrangements the commissioner shall take into account reasonable projections of enrollments, claims and administrative costs, financial guarantees given to the organization, the financial condition of any guarantors and other relevant information.

(f) *Setting greater amounts.* The commissioner may require, based on the actual operating experience of a particular insurer, greater amounts under pars. (a), (d) and (e) on finding that the financial stability of the organization requires it. Higher financial standards may be applied to a limited service health organization which does not transfer all of the risk to individual providers.

(g) *Insolvency protection for policyholders.* Each limited service health organization which provides hospital benefits shall demonstrate that, in the event of an insolvency, enrollees hospitalized at the time of an insolvency will be covered until discharged.

(5) BUSINESS PLAN. All applications for certificates of incorporation and certificates of authority of a limited service health organization shall include a proposed business plan. Limited service health organizations that are not separately licensed shall submit a proposed business plan prior to doing business as a limited service health organization unless the commissioner waives this requirement. In addition to the items listed in ss. 611.13 (2) and 613.13 (1), Stats., the business plan shall contain the following information:

(a) *Identity of organization.* The name and address of the limited service health organization and the names and addresses of individual providers, if any, who control the limited service health organization.

(b) *Organization type.* The type of organization, including information on whether providers will be salaried employes of the organization or individual or group contractors.

(c) *Feasibility study.* A feasibility study which supports the financial and enrollment projections of the plan, including the potential number of enrollees in the geographical service area, the estimated number of enrollees for the first five years, the underwriting standards to be applied, and the method of marketing the organization.

(d) *Geographical service area.* The geographical service area by county including a chart showing the number of primary and specialty care providers with locations and service areas by county; the method of handling emergency care, with locations of emergency care facilities; and the method of handling out-of-area services.

(e) *Provider agreements.* The extent to which any of the following are or are not included in provider agreements and the form of any provisions which:

1. Limit the providers' ability to seek reimbursement for covered services from policyholders or enrollees;

2. Permit or require the provider to assume a financial risk in the limited services health organization, including any provisions for assessing the provider, adjusting capitation or fee-for-service rates, or sharing in the earnings or losses of the organization; or

3. Govern amending or terminating the agreement or the effect of amending or terminating the agreement.

(f) *Plan administration.* 1. A copy of the administrative agency contract if management or administrative authority for the operation of the limited service health organization is delegated to a person or organization outside of the limited service health organization. This administration contract shall include a description of the services to be provided, the standards of performance for the administrative agent, the method of payment, including any provisions for the administrative agent to participate in profit or losses in the plan, the duration of the contract and any provisions for modifying, terminating, or renewing the contract.

2. A summary of how the limited service health organization will provide administrative services, including size and qualifications of the administrative staff, and the projected cost of administration in relation to premium income shall accompany the application if a limited service health organization provides its own administrative services and does not delegate these functions to a person or organization outside of the limited service health organization.

(g) *Financial projections.* A summary of current and projected enrollment, income from premiums by type of payor, other income, administrative and other costs, the projected break even point, including the method of funding the accumulated losses until the income and expense reach the break even point, and a summary of the assumptions made in developing projected operating results.

(h) *Financial guarantees.* A summary of all financial guarantees by providers, sponsors, affiliates or parents within a holding company system, or any other guarantees which are intended to ensure the financial success of the plan. Such guarantees include, but are not limited to, hold harmless agreements by providers, insolvency insurance, reinsurance or other guarantees.

(i) *Contracts with enrollees.* A summary of benefits to be offered enrollees including any limitations and exclusions and the renewability of all contracts to be written.

(6) CHANGES IN THE BUSINESS PLAN. All substantial changes, alterations or amendments to the business plan shall be filed with the commissioner at least 30 days prior to their effective date and shall be subject to disapproval by the commissioner. These include changes to articles and bylaws, organization type, geographical service area, provider agreements, provider availability, plan administration, financial projections and guarantees and any other change which might affect the financial solvency of the plan. Any changes in the items listed in sub. (5) (e) shall be filed under this section.

(7) PROVIDER AGREEMENTS. (a) Prior to doing business, all limited service health organizations shall file with the commissioner copies of all executed provider agreements and other contracts covering its liabilities except that a limited service health organization may file a list of provid-

ers executing a standard contract and a copy of the form of the contract instead of copies of the individual executed contracts.

(b) A limited service health organization shall maintain executed copies of all provider agreements in its administrative office and shall make the copies available to the commissioner on request.

(8) OTHER REPORTING REQUIREMENTS. (a) A limited service health organization shall file an annual statement for the preceding year with the commissioner by March 1 of each year and shall put the statement on the current health maintenance organization annual statement blank prepared by the national association of insurance commissioners.

(b) The commissioner may require other reports on a regular or other basis as appropriate.

(9) POLICY AND CERTIFICATE LANGUAGE REQUIREMENTS. Each policy form marketed by a limited service health organization and each certificate given to enrollees shall contain:

(a) A definition of geographical service area, emergency care, urgent care, out-of-area services, dependents and primary provider, if these terms or terms of similar meaning are used in the policy or certificate and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the policy or certificate if the definition is adequately described in an attachment which is given to all enrollees along with the policy or certificate.

(b) Clear disclosure in the exclusions, limitations, and exceptions section of any provision which limits benefits or access to service. The exclusions, limitations and exceptions which shall be disclosed include those relating to emergency and urgent care, restrictions on the selection of primary or referral providers, restrictions on changing providers during the contract period, out-of-pocket costs including copayments and deductibles, charges for missed appointments or other administrative sanctions, restrictions on access to care if copayments or other charges are not paid, and any restrictions on coverage for dependents who do not reside in the service area.

(10) GRIEVANCE PROCEDURE. (a) Each limited service health organization shall develop an internal grievance procedure which shall be described in each policy and certificate issued to enrollees. Policies and certificates shall include a definition of a grievance.

(b) In addition to the notice requirement in par. (a), each time the limited service health organization denies a claim and each time it initiates disenrollment proceedings under sub. (12) (b) 5, the limited service health organization shall notify the affected enrollee of the right to file a grievance and the procedure to follow.

(c) The limited service health organization shall acknowledge a grievance within 10 days of receiving it.

(d) The limited service health organization shall retain records of all grievances for 3 years and shall develop a summary each year which shall include the date each grievance was filed, the nature of the grievance, the date of the resolution of the grievance, a summary of the resolution of the grievance, and a comment concerning any administrative changes made as a result of the grievance. This summary shall be filed with the commis-

sioner by February 1 each year for the preceding year in a form prescribed by the commissioner.

(11) OTHER NOTICE REQUIREMENTS. Prior to enrolling members, the limited service health organization shall provide to all prospective group or individual policyholders information on the plan, including information on the services covered, a definition of emergency and out-of-area coverage, names and specific location of providers for each type of service, the cost of the plan, enrollment procedures, and limitations on benefits including limitations on choice of providers and the geographical area served by the organization.

(12) DISENROLLMENT. (a) The limited service health organization shall clearly disclose in the policy and certificate any circumstances under which the limited service health organization may disenroll an enrollee.

(b) The limited service health organization may disenroll a member from the limited service health organization for the following reasons only:

1. The policyholder has failed to pay required premiums by the end of the grace period.

2. The enrollee has committed acts of physical or verbal abuse which pose a threat to providers or other members of the organization.

3. The enrollee has allowed a nonmember to use the limited service health organization's membership card or has knowingly provided fraudulent information in applying for coverage with the limited service health organization or in receiving services.

4. The enrollee has moved outside of the geographical service area of the organization.

5. The enrollee is unable to establish or maintain a satisfactory provider-patient relationship with the provider responsible for the enrollee's care. Disenrollment of an enrollee for this reason shall be permitted only if the limited service health organization can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care provider, made a reasonable effort to assist the enrollee in establishing a satisfactory provider-patient relationship and informed the enrollee that he or she may file a grievance on this matter.

(c) A limited service health organization that has disenrolled an enrollee for any reason except failure to pay required premiums shall make arrangements to provide similar insurance coverage to the enrollee. In the case of group certificate holders this insurance coverage shall be continued until the person is able to find similar coverage or until the next opportunity to change insurers, whichever comes first. In the case of an enrollee covered on an individual basis, coverage shall be continued until the anniversary date of the policy or for one year, whichever is earlier.

(13) TIME PERIOD FOR REVIEW. In accordance with s. 227.116, Stats., the commissioner shall review and make a determination on an application for a certificate of authority within 60 business days after it has been received.

(14) Subs. (9), (10), (11) and (12) shall apply to all policies issued or renewed on or after January 1, 1987.

Note: Section Ins 3.51 shall not apply to policies issued or renewed before January 1, 1987.

History: Cr. Register, November, 1986, No. 371, eff. 12-1-86.