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 deter-

mining 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-

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priately included in the home care plan or not necessary to prevent or postpone confinement in a hospital or skilled nursing facilility only if:

1. The insurer has a reasonable, and documented factual basis for the determination; and

2. The basis for the determination is communicated to the insured in writing.

(d) In determining whether a home care claim, including a claim for home health aide services, is reimbursable under a disability insurance policy, an insurer may apply claim review criteria to determine that home is an appropriate treatment setting for the patient and that it is not reasonable to expect the patient to obtain medically necessary services or supplies on an outpatient basis, subject to the requirements of s. 632.895 (2) (g), Stats.

(e) An insurer shall disclose and clearly define the home care benefits and limitations in a disability insurance policy, certificate and outline of coverage. An insurer may not use the terms "homebound" or "custodial" in the sections of a policy describing home care benefits, exclusions, limitations, or reductions.

(f) In determining whether a home care claim under a disability insurance policy involves medically necessary part-time or intermittent care, an insurer shall give due consideration to the circumstances of each claimant and may not make arbitrary decisions concerning the number of home care visits within a given period which the insurer will reimburse. An insurer may not deny a claim for home care visits without properly reviewing and giving due consideration to the plan of care established by the attending physician under s. 632.895 (1) (b), Stats. An insurer may use claim review criteria based on the number of home care visits in a period for the purpose of determining whether a more thorough review of a home care claim or plan is conducted.

(g) An insurer may use claim review criteria under par. (d) or (f) only if the criteria and review process do not violate s. Ins 6.11. An insurer shall comply with s. 628.34 (1), Stats., when communicating claim review criteria to applicants, insureds, providers or the public.

Note: Section Ins 3.54 applies to disability insurance policies issued or renewed on or after June 1, 1987.

History: Cr. Register, April, 1976, No. 376, eff. 6-1-87.

Ins 3.55 Benefit appeals under nursing home insurance policies and medicare replacement or supplement policies. (1) PURPOSE. This section implements and interprets s. 632.84, Stats., for the purpose of establishing minimum requirements for the internal procedure for benefit appeals that insurers shall provide in nursing home insurance policies and Medicare replacement or supplement policies. This section also facilitates the review by the commissioner of these policy forms.

(2) SCOPE. This section applies to individual and group nursing home insurance policies and Medicare replacement or supplement policies issued or renewed on or after August 1, 1988. This section does not apply to a health maintenance organization, limited service health organization, or preferred provider plan, as those are defined in s. 609.01, Stats.

(3) DEFINITIONS. In this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) REPORTS TO THE COMMISSIONER. An insurer shall report to the commissioner by March 31 of each year a summary of all benefit appeals filed during the previous calendar year and the disposition of these appeals, including:

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

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

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

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

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

(f) The nature of each benefit appeal; and

(g) A summary of each benefit appeal resolution.

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

History: Cr. Register, May, 1989, No. 401, eff. 1-1-90.