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.

Ins 3.40 Coordination of benefits provisions in group and blanket disability insurance policies. (1) PURPOSE. (a) This section establishes authorized coordination of benefits provisions for group and blanket disability insurance policies pursuant to s. 631.23, Stats. It has been found that these clauses are necessary to provide certainty of meaning. Regulation of contract forms will be more effective, and litigation will be substantially reduced if there is uniformity regarding coordination of benefits provisions in health insurance policies.

(b) A Coordination of benefits (COB) provision as defined in sub. (3) (e) avoids claim payment delays be establishing an order in which Plans pay their claims and by providing the authority for the orderly transfer of information needed to pay claims promptly. It avoids duplication of benefits by permitting a reduction of the benefits of a Plan when, by the rules established by this section, a Plan does not have to pay its benefits first.

(c) Coordinating health benefits has been found to be an effective tool in containing health care costs. However, minimum standards of protection and uniformity are needed to protect the insured's and the public's interest.

(2) SCOPE. This section applies to all group and blanket disability insurance policies subject to s. 631.01 (1), Stats., that provide 24-hour continuous coverage for medical or dental care, treatment or expenses due to either injury or sickness that contain a coordination of benefits provision, an "excess," "anti-duplication," "non-profit" or "other insurance" exclusion by whatever name designated under which benefits are reduced because of other insurance, other than an exclusion for expenses covered by worker's compensation, employer's liability insurance, Medicare, medical assistance or individual traditional automobile "fault" contracts. Except as permitted under s. 632.32 (4) (b), Stats., this section applies to the medical benefits provisions in an automobile "no fault" type or group or group-type "fault" policy.

(3) DEFINITIONS. In this section:

(a) "Allowable expense" means the necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made, except as provided in sub. (4).

(b) "Claim" means a request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of services (including supplies), payment for all or a portion of the expenses incurred, a combination of the previuos 2, or indemnification.

(c) "Claim determination period" means the period of time, not less than 12 consecutive months, over which allowable expenses are compared with total benefits payable in the absence of COB to determine whether overinsurance exists and how much each Plan will pay or provide. However, it does include any part of a year before the date this COB provision or a similar provision takes effect.

(d) "Complying Plan" means a Plan with order of benefit determination rules which comply with this section.

(e) A "Coordination of benefits (COB) provision" means an insurance contract provision intended to avoid claims payment delays and duplica-

tion of benefits when a person is covered by 2, or more plans providing benefits or services for medical, dental or other care or treatment.

(f) "Group-type contracts" means contracts which are not available to the general public and may be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition of Plan at the option of the insurer issuing group-type plans or the service provider and its contract-client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, "franchise" or "blanket"). The use of payroll deductions by the employe, subcriber or member to pay for the coverage is not sufficient, of itself, to make an individual contract part of a group-type plan. Group-type contracts do not include individually underwritten and issued, guaranteed renewable policies that may be purchased through payroll deduction at a premium savings to the insured.

(g) "Hospital indemnity benefits" means benefits for hospital confinement which are not related to expenses incurred but does not include plans that reimburse a person for actual hospital expenses incurred even if the plans are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Next page is numbered 151

tion those people responsible for making the determination which resulted in the grievance. The preferred provider plan shall inform the enrollee in writing of the time and place of the meeting at least 7 calendar days before the meeting.

(e) Pars. (b), (c) and (d) do not apply in urgent care situations. Preferred provider plans shall develop a separate grievance procedure for urgent care situations. This procedure shall require a preferred provider plan to reslove an urgent care situation grievance within 4 business days of receiving the grievance.

(f) Preferred provider plans shall record, retain, and report records for each complaint and grievance in accordance with all of the following requirements:

1. Each preferred provider plan shall keep and retain for at least a three-year period a record for each complaint and grievance submitted to the preferred provider plan.

2. Each provider contract and administrative services agreement entered into between a preferred provider plan and a provider shall contain a provision under which the provider must identify complaints and grievances and forward these complaints and grievances in a timely manner to the preferred provider plan for recording and resolution.

3. Each preferred provider plan shall submit the grievance experience report required by s. 609.15 (1) (c), Stats., to the commissioner by March 1 of each year. The report shall provide information on grievances that were formally reveiwed by a grievance panel of the preferred provider plan during the previous calendar year. For purposes of this report, the preferred provider plan shall classify each grievance as follows:

a. Plan administration. A grievance related to plan marketing, policyholder service, billing, underwriting, or similar administrative functions; or

b. Benefits denials. A grievance related to the denial of a benefit, including grievances related to refusals to refer enrollees or provide requested services.

4. Each preferred provider plan shall keep together in a central location of the preferred provider plan all records on complaints and grievances resolved before a formal review by a grievance panel is completed or in which the enrollee does not pursue a resolution. Preferred provider plans shall make these records available for review during examination by or on request of the commissioner.

(g) The commissioner shall by June 1 of each year prepare a report that summarizes grievance experience reports received by the commissioner from preferred provider plans. The report shall also summarize complaints involving preferred provider plans that were received by the office during the previous calendar year.

History: Cr. Register, June, 1984, No. 342, eff. 7-1-84; r. (7) under s. 13.93 (2m) (b) 16., Stats., Register, December, 1984, No. 348; am. (1) and (4) (a), r. (6), Register, September, 1986, No. 369, eff. 10-1-86; renum. (2) to (5) to be (3) to (6), cr. (2) and (7), Register, October, 1989, No. 406, eff. 1-1-90.

Ins 3.49 Wisconsin automobile insurance plan. (1) PURPOSE. This section interprets s. 619.01 (6), Stats., to continue a plan to make automo-

bile insurance available to those who are unable to obtain it in the voluntary market by providing for the equitable distribution of applicants among insurers and outlines access and grievance procedures for such a plan.

(2) DEFINITIONS. In this section:

(a) "Committee" means the governing committee of the Wisconsin Automobile Insurance Plan which is the group of companies administering the Plan.

(b) "Plan" means the Wisconsin Automobile Insurance Plan, an unincorporated facility established by s. 204.51 [Stats., (1967)] and continued under s. 619.01 (6), Stats.

(3) FILING AND ACCESS. The committee shall submit revisions to its rules, rates and forms for the Plan to the commissioner. Prior approval by the commissioner of the documents is required before they may become effective. The documents shall provide:

(a) Reasonable rules governing the equitable distribution of risks by direct insurance, reinsurance or otherwise and their assignment to insurers;

(b) Rates and rate modifications applicable to such risks which shall not be excessive, inadequate or unfairly discriminatory;

(c) The limits of liability which the insurer shall be required to assume;

(d) A method by which an applicant to the Plan denied insurance or an insured under the Plan whose insurance is terminated may request the committee to review such denial or termination and by which an insurer subscribing to the Plan may request the committee to review actions or decisions of the Plan which adversely affect such insurer. The method shall specify that such requests for review must be made in writing to the Plan and that the decision of the committee in regard to such review may be appealed by the applicant, insured, or company to the commissioner of insurance as provided for in ch. Ins 5. A review or appeal does not operate as a stay of termination.

Note: These requirements reflect former s. 204.51 (2), Stats.

(e) The commissioner shall maintain files of the Plan's approved rules, rates, and forms and such documents must be made available for public inspection at the office of the commissioner of insurance.

History: Cr. Register, November, 1984, No. 347, eff. 12-1-84.

Ins 3.50 Health maintenance organizations. (1) PURPOSE. This section establishes financial and other standards for health maintenance organizations doing business in Wisconsin. These requirements are in addition to any other statutory or administrative rule requirements which apply to health maintenance organizations.

(2) SCOPE. This section applies to all insurers writing health maintenance organization business in this state.

(3) DEFINITIONS. In this section:

(b) "Complaint" means any dissatisfaction about an insurer or its contracted providers expressed by an enrollee.

(c) "Grievance" means any dissatisfaction with the administration or claims practices of or provision of services by a health maintenance organization which is expressed in writing by or on behalf of a plan enrollee.

(d) "Health maintenance organization" means a health care plan as defined in s. 609.01 (2), Stats.

(e) "Health maintenance organization insurer" has the meaning provided under s. 600.03 (23c), Stats. "Health maintenance organization insurer" does not include a limited service health organization.

(4) FINANCIAL REQUIREMENTS. (a) *Capital.* Unless otherwise ordered by the commissioner the minimum capital or permanent surplus of:

1. A health maintenance organization insurer first licensed or organized on or after July 1, 1989, is $750,000;

2. A health maintenance organization insurer first licensed or organized prior to July 1, 1989, is $200,000;

3. Any other insurer writing health maintenance organization business, is the amount of capital or required surplus required under the statutes governing the organization of the insurer.

(b) *Compulsory surplus.* An insurer, including an insurer organized under ch. 613, Stats., writing health maintenance organization business, except for a health maintenance organization insurer, is subject to s. Ins 14.02. A health maintenance organization insurer shall maintain compulsory surplus as follows, or a greater amount required by order of the commissioner:

1. Prior to January 1, 1991, at least the greater of $500,000 or an amount equal to the sum of:

a. 10% of premium earned in the previous 12 months for policies which include coverages which are other insurance business under s. 609.03 (a) 3, Stats.; plus

b. 3% of all other premium earned in the previous 12 months.

2. In calendar year 1991, at least the greater of $500,000 or an amount equal to the sum of:

a. 10% of premium earned in the previous 12 months for policies which include coverages which are other insurance business under s. 609.03 (3) (a) 3, Stats.; plus

b. 3% of other premiums earned in the previous 12 months except that if the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is less than 90%, 4.5% of other premium earned in the previous 12 months.

3. Beginning on January 1, 1992, at least the greater of $750,000 or an amount equal to the sum of:

a. 10% of premiums earned in the previous 12 months for policies which include coverages which are other insurance business under s. 609.03 (3) (a) 3, Stats.; plus

b. 3% of other premium earned in the previous 12 months except that if the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is less than 90%, 6% of other premiums earned in the previous 12 months.

(c) *Risks.* Risks and factors the commissioner may consider in determining whether to require greater compulsory surplus by order include, but are not limited to, those described under s. 623.11 (1) (a) and (b), Stats., and the extent to which the insurer effectively transfers risk to providers. A health maintenance organization insurer may transfer risk through any mechanism including, but not limited to, those provided under sub. (5) (d).

(d) *Security surplus.* An insurer, including an insurer organized under ch. 613, Stats., writing health maintenance organization insurance business, except for a health maintenance organization insurer, is subject to s. Ins 14.02. A health maintenance organization insurer should maintain a security surplus to provide an ample margin of safety and clearly assure a sound operation. The security surplus of a health maintenance organization insurer shall be at least the greater of:

1. Compulsory surplus plus 40% reduced by 1% for each $33 million of premium in excess of $10 million earned in the previous 12 months; or

2. 110% of its compulsory surplus.

(e) *Insolvency protection for policyholders.* Each health maintenance organization insurer is required to either maintain compulsory surplus as required for other insurers under s. Ins 14.02 or to demonstrate that in the event of insolvency:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and

2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or pre-existing limitation requirements.

(f) *Setting greater amounts.* The commissioner may set greater amounts under pars. (a) to (d) on finding that the financial stability of the organization requires it.

(h) *Existing insurers.* For health maintenance organizations having a Certificate of Authority on September 29, 1986, this subsection shall become effective on January 1, 1988.

(5) BUSINESS PLAN. All applications for certificates of incorporation and certificates of authority of a health maintenance organization insurer shall include a proposed business plan. In addition to the items listed in ss. 611.13 (2) and 613.13 (1), Stats., the following information shall be contained in the business plan:

(a) *Organization type.* The type of health maintenance organization insurer, including whether the providers affiliated with the organization will be salaried employes or group or individual contractors.

(b) *Feasibility studies and marketing surveys.* A summary of feasibility studies or marketing surveys which support the financial and enrollment projections for the health maintenance organization insurer. The summary shall include the potential number of enrollees in the operating ter-

ritory, the projected number of enrollees for the first 5 years, the underwriting standards to be applied, and the method of marketing the organization.

(c) *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.

(d) *Provider agreements.* The extent to which any of the following will be 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 health maintenance organization insurer, including any provisions for assessing the provider, adjusting capitation or fee-for-service rates, or sharing in the earnings or losses; and

3. Govern amending or terminating agreements with providers.

(e) *Provider availability.* A description of how services will be provided to policyholders in each service area including the extent to which primary care will be given by providers under contract to the health maintenance organization insurer.

(f) *Plan administration.* A summary of how administrative services will be provided, including the size and qualifications of the administrative staff and the projected cost of administration in relation to premium income. If management authority for a major corporate function is delegated to a person outside the organization, the business plan shall include a copy of the contract. The contract shall include the services to be provided, the standards of performance for the manager, the method of payment including any provisions for the administrator to participate in the profit or losses of the plan, the duration of the contract and any provisions for modifying, terminating or renewing the contract. Contracts for delegated management authority shall be filed for approval with the commissioner under ss. 611.67 and 618.22, Stats.

(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 break even point is reached, 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 health maintenance organization insurer. These include 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. A health maintenance organization insurer shall file a written report of any proposed substantial change in its business plan. The insurer shall file the report at least 30 days prior to the effective date of the change. The office may disapprove the change. The insurer may not enter into any transaction, contract, amendment to a transaction or contract or take action or make any omission which is a substantial change in the insurer's business plan prior to the effective date of the change or if the change is disapproved. Substantial changes include changes in articles and bylaws, organization type, geographical service areas, 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) (d) shall be filed under this section.

(7) COPIES OF PROVIDER AGREEMENTS. All health maintenance organization insurers shall file with the commissioner, prior to doing business, copies of all executed provider agreements and other contracts covering liabilities of the health maintenance organization, except that, for contracts with physicians, a list of physicians executing a standard contract and a copy of the form of the contract may be filed instead of copies of the executed contracts. Executed copies of all provider agreements, including those with physicians, shall be maintained in the insurer's administrative office and shall be made available to the commissioner on request.

(8) OTHER REPORTING REQUIREMENTS. (a) All insurers authorized to write health maintenance organization business shall file with the commissioner by March 1 of each year an annual statement for the preceding year. A health maintenance organization insurer shall use the current Health Maintenance Organization annual statement blank prepared by the national association of insurance commissioners. All other insurers shall file an annual report in a form prescribed by the commissioner. A health maintenance organization insurer shall include with its annual statement a statement of covered expenses, and a special procedures opinion from a certified public accountant, in the form prescribed by the commissioner as Appendix B.

(b) A health maintenance organization insurer shall file a quarterly report, including a report concerning covered expenses, in a form prescribed by the commissioner, within 45 days after the close of each of the first 3 quarters of the year unless the commissioner has notified the insurer that another reporting schedule is appropriate.

(c) A health maintenance organization insurer shall include with its annual audit financial reports filed under s. Ins 16.02 a statement of covered expenses and an audit opinion concerning the statement. Both the statement and opinion shall be in the form prescribed by the commissioner as Appendix C.

(d) An insurer writing health maintenance organization business, other than a health maintenance organization insurer, shall file a quarterly report in a form prescribed by the commissioner within 45 days after the close of each of the first 3 quarters of the year unless the commissioner notifies the insurer that another reporting schedule is appropriate.

(e) 1. If a health maintenance organization insurer fails to file a statement or opinion required under pars. (a) to (c) by the time required, it is presumed, in any action brought by the office within one year of the due

date, that the health maintenance organization insurer is in financially hazardous condition and that the percentage of its liabilities for health care costs which are covered liabilities is and continues to be less than 65% for the purpose of s. 609.95, Stats.

2. It is presumed that the percentage of liabilities which are covered liabilities of a health maintenance organization insurer is and continues to be not greater than the percentage of covered expenses stated in the report or statement filed under pars. (a) to (d) for the most recent period.

3. The health maintenance organization insurer has the burden of refuting a presumption under subd. 1 or 2.

(8g) TERMINATION OF HOLD HARMLESS. (a) Notice of election to be exempt from s. 609.91 (1) (b), Stats., or notice of termination of election to be subject to s. 609.91 (1) (c), Stats., is effective only if filed on the form prescribed by the commissioner and if the form is properly completed.

(b) A health care provider shall use the form prescribed by the commissioner for filing notice of termination of election to be exempt under s. 609.91 (1) (b), Stats., or notice of termination of election to be subject to s. 609.91 (1) (c), Stats. A filing which is not on the prescribed form is not effective. If a provider fails to use or to properly complete the form prescribed for notice of termination of election to be exempt from s. 609.91 (1) (b), Stats., or notice of election to be subject to s. 609.91 (1) (c), Stats., the filing is nevertheless effective.

(8m) RECEIVABLES FROM AFFILIATES. A receivable, note or other obligation of an affiliate to a health maintenance organization insurer shall be valued at zero by the insurer for all purposes including, but not limited to, for the purpose of reports or statements filed with the office, unless the commissioner specifically approves a different value. The different value shall be not more than the amount of the receivable, note or other obligation which is fully secured by a security interest in cash or cash equivalents held in a segregated account or trust.

(8s) RECEIVABLES FROM IPA. After December 31, 1990, a health maintenance organization insurer shall value receivables, notes or obligations of individual practice associations as defined under s. 600.03 (23g), Stats., at zero for all purposes including, but not limited to, for the purpose of reports or statements filed with the office, unless the receivable, note or obligation is fully secured by a security interest in cash or cash equivalents held in a segregated account or trust.

(8u) INCIDENTAL OR IMMATERIAL INDEMNITY BUSINESS IN HEALTH MAINTENANCE ORGANIZATIONS. (a) Except as provided by par. (b), insurance business is not incidental or immaterial under s. 609.03 (3) (a) 3, Stats., if a health maintenance organization insurer issues coverage which is not typically included in a health maintenance organization or limited service health organization policy and the insurer either:

1. Markets the policy containing the coverage; or

2. The total premium for policies containing the coverage exceeds or is projected to exceed 5% of total premium earned in any 12-month period.

(b) Insurance business is incidental or immaterial under s. 609.03 (3) (a) 3, Stats., if the business is written according to the terms of a specific business plan for issuance of coverage under s. 609.03 (3) (a) 3, Stats.,

and the business plan is approved in writing by the office. A request for approval to do business under this paragraph including, but not limited to, issuance of policies with point of service coverage, shall include a detailed business plan, a copy of the policy form, a detailed description of how the business will be marketed and premium volume controlled, and other information prescribed by the office. The total premium for policies containing coverages subject to this paragraph and policies issued under par. (a) may not exceed 10% of premium earned or projected to be earned in any 12-month period.

(c) If the commissioner approves insurance business as incidental or immaterial the commissioner may also, by order under sub. (4) (b), require the insurer to maintain more than the minimum compulsory surplus.

(d) For the purpose of this section any coverage which covers services by a provider other than a selected provider is not typically included in a health maintenance organization or limited service health organization policy, except coverage of emergency out-of-area services.

(8x) SUMMARY. A health maintenance organization insurer shall use the form prescribed in Appendix A to comply with s. 609.94, Stats.

(8z) NONDOMESTIC HMO. No certificate of authority may be issued under ch. 618, Stats., on or after September 1, 1990, to a person to do health maintenance organization or limited service health organization business in this state unless the person is organized and regulated as an insurer and domiciled in the United States. Any person issued a certificate of authority under ch. 618, Stats., to do health maintenance organization business prior to the effective date of this rule which is not organized and regulated as an insurer and domiciled in the United States shall cease doing business in this state not later than January 1, 1993.

(9) POLICY AND CERTIFICATE LANGUAGE REQUIREMENTS. Each policy form marketed by a health maintenance 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 such definition is adequately described in an attachment which is given to all enrollees along with the policy or certificate.

(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 de-

pendent children, alcoholism and other drug abuse, and nervous and mental disorders.

(10) GRIEVANCE PROCEDURE. (a) A health maintenance organization shall investigate each grievance pursuant to s. 609.15 (2), Stats. 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 benefit, including a refusal to refer an enrollee, 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. The notification shall state the specific reason for the denial or initiation.

(c) The health maintenance organization shall resolve all grievances within 30 calendar days of receiving the grievance. If the health maintenance organization is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days if the health maintenance organization notifies, in writing, the person who filed the grievance that the health maintenance organization has not resolved the grievance, when resolution may be expected, and the reason for why additional time is needed.

(d) A grievance procedure shall include a method whereby the enrollee who made the grievance has the right to appear in person before the grievance committee to present written or oral information and to question those people responsible for making the determination which resulted in the grievance. The health maintenance organization shall inform the enrollee in writing of the time and place of the meeting at least 7 calendar days before the meeting.

(e) Pars. (b), (c) and (d) do not apply in urgent care situations. Health maintenance organizations shall develop a separate grievance procedure for urgent care situations. This procedure shall require a health maintenance organization to resolve an urgent care situation grievance within 4 business days of receiving the grievance.

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

(g) Health maintenance organizations shall record, retain, and report records for each complaint and grievance in accordance with all of the following requirements:

1. Each health maintenance organization shall keep and retain for at least a three-year period a record for each complaint and grievance submitted to the health maintenance organization.

2. Each provider contract and administrative services agreement entered into between a health maintenance organization and a provider shall contain a provision under which the provider must identify complaints and grievances in a timely manner and forward these complaints and grievances in a timely manner to the health maintenance organization for recording and resolution.

3. Each health maintenance organization shall submit a grievance experience report required by s 609.15 (1) (c), Stats., to the commissioner by March 1 of each year. The report shall provide information on grievances received during the previous calendar year that were formally reviewed by a grievance panel of the health maintenance organization. For purposes of this report, the health maintenance organization shall classify each grievance as follows:

a. Plan administration. A grievance related to plan marketing, policyholder service, billing, underwriting, or similar administrative functions; or

b. Benefits denials. A grievance related to the denial of a benefit, including grievances related to refusals to refer enrollees or provide requested services.

4. Each health maintenance organization shall keep together in a central location of the health maintenance organization all records on complaints and grievances resolved before a formal review by a grievance panel is completed or in which the enrollee does not pursue a resolution. The health maintenance organization shall make these records available for review during examinations by or on request of the commissioner.

(h) The commissioner shall by June 1 of each year prepare a report that summarizes grievance experience reports received by the commissioner from health maintenance organizations. The report shall also summarize complaints involving health maintenance organizations that were received by the office during the previous calendar 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; renum. (3) (b) and (10) (c) to be (3) (d) and (10) (f), r. (10) (d), cr. (3) (b) and (c), (10) (c) to (e), (g) and (h), am. (10) (a) and (b), Register, October, 1989, No. 406, eff. 1-1-90; r. and recr. (2) and (4) (a) to (c), r. (3) (a) and (4) (e), renum. (4) (f) and (g) to be (4) (e) and (f) and am. (4) (e) (intro.) and (4) (f), cr. (3) (intro.) and (e), (8) (c) to (e), (8g), (8s), (8u), (8x) and (8z), am. (4) (d) (intro.), (5) (intro.) to (b), (d) 2., (e) and (h) and (6) to (8), Register, August, 1990, No. 416, eff. 9-1-90.

Ins 3.50 Appendix A

NOTICE

THIS NOTICE DESCRIBES HOLD-HARMLESS PROVISIONS WHICH AFFECT YOUR ABILITY TO SEEK RECOURSE AGAINST HMO ENROLLEES FOR PAYMENT FOR SERVICES

Section 609.94, Wis. Stat., requires each health maintenance organization insurer (HMO) to provide a summary notice to all of its participating providers of the statutory limitations and requirements in §§ 609.91 to 609.935, and § 609.97 (1), Wis. Stat.

SUMMARY

Under Wisconsin law a health care provider may not hold HMO enrollees or policyholders ("enrollees") liable for costs covered under an HMO policy if the provider is subject to statutory provisions which "hold harmless" the enrollees. For most health care providers application of the statutory hold-harmless is "mandatory" or it applies unless the provider elects to "opt-out." A provider permitted to "opt-out" must file timely notice with the Wisconsin Office of the Commissioner of Insurance ("OCI").

Some types of provider care are subject to the statutes only if the provider voluntarily "opts-in." An HMO may partially satisfy its regulatory capital and surplus requirements if health care providers elect to remain subject to the statutory hold-harmless provisions.

This notice is only a summary of the law. Every effort has been made to accurately describe the law. However, if this summary is inconsistent with a provision of the law or incomplete, the law will control.

Filings for exemption with OCI must be on the prescribed form to be effective.

HOLD HARMLESS

A health care provider who is subject to the statutory hold-harmless provisions is prohibited from seeking to recover health care costs from an enrollee. The provider may not bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency or have any recourse against an enrollee or any person acting on the enrollee's behalf, for health care costs for which the enrollee is not liable. The prohibition on recovery does not effect the liability of an enrollee for any deductibles or copayments, or for premiums owed under the policy or certificate issued by the HMO.

A. MANDATORY FOR HOLD HARMLESS

An enrollee of an HMO is not liable to a health care provider for health care costs which are covered under a policy issued by that HMO if:

1. Care is provided by a provider who is an affiliate of the HMO, owns at least 5% of the voting securities of the HMO, is directily or indirectly invloved with the HMO through direct or indirect selection of or representation by one or more board members, or is an Individual

Practice Association ("IPA") and is represented, or an affiliate is represented, by one of at least three HMO board members who directly or indirectly represent one or more Independent Practice Associations ("IPAs") or affiliates of IPAs; or,

2. Care is provided by a provider under a contract with or through membership in an organization identified in 1.; or

3. To the extent the charge exceeds the amount the HMO has contractually agreed to pay the provider for that health care service; or

4. The care is provided to an enrolled medical assistance recipient under a Department of Health and Social Services prepaid health care policy.

B. "OPT-OUT" HOLD HARMLESS

If the conditions described in A do not apply, the provider will be subject to the statutory hold harmless unless the provider files timely election with OCI to be exempt if the health care is:

1. Provided by a hospital or an IPA; or

2. A physician service, or other provider services, equipment, supplies or drugs that are ancillary or incidental to such services and are provided under a contract with the HMO or are provided by a provider selected by the HMO; or

3. Provided by a provider, other than a hospital, under a contract with or through membership in an IPA which has not elected to be exempt. Note that only the IPA may file election to exempt care provided by its member providers from the statutory hold harmless. (See Exemptions and Elections, No. 4.)

C. "OPT-IN" HOLD HARMLESS

If a provider of health care is not subject to the conditions described in A or B, the provider may elect to be subject to the statutory hold-harmless provisions by filing a notification with OCI stating that the provider elects to be subject with respect to any specific HMO. A provider may terminate such a notice of election by stating the termination date in that notice or in a separate notification.

CONDITIONS NOT AFFECTING IMMUNITY

An enrollee's immunity under the statutory hold harmless is not affected by any of the following:

1. Any agreement entered into by a provider, an HMO, or any other person, whether oral or written, purporting to hold the enrollee liable for costs (except a notice of election or termination permitted under the statute;

2. A breach of or default on any agreement by the HMO, an IPA, or any other person to compensate the provider for health care costs for which the enrollee is not liable.

3. The insolvency of the HMO or any person contracting with the HMO, or the commencement of insolvency, delinquency or bankruptcy proceedings involving the HMO or other persons which

would affect compensation for health care costs for which an enrollee is not liable under the statutory hold harmless;

4. The inability of the provider or other person who is owed compensation to obtain compensation for health care costs for which the enrollee is not liable;

5. Failure by the HMO to provide notice to providers of the statutory hold-harmless provisions; or

6. Any other conditions or agreement existing at any time.

EXEMPTIONS AND ELECTIONS

Hospital, IPAs, and providers of physician services who may "opt-out" may elect to be exempt from the statutory hold harmless and prohibition on recovery of health care costs under the following conditions and with the following notifications:

1. If the hospital, IPA, or other provider has a written contract with the HMO, the provider must within thirty (30) days after entering into that contract provide a notice to the OCI of the provider's election to be exempt from the statutory hold-harmless and recovery limitations for care under the contract.

2. If the hospital, IPA, or other provider does not have a contract with an HMO, the provider must notify OCI that it intends to be exempt with respect to a specific HMO and must provide that notice for the period January 1, 1990, to December 31, 1990, at least sixty (60) days before the health care costs are incurred; and must provide that notice for health care costs incurred on and after January 1, 1991, at least 90 days in advance.

3. A provider who submits a notice of election to be exempt may terminate that election by stating a termination date in the notice or by submitting a separate termination notice to OCI.

4. The election by an IPA to be exempt from the statutory provisions, or the failure of an IPA to so elect, applies to costs of health care provided by any provider, other than a hospital, under contract with or through membership in the IPA. Such a provider, other than a hospital, may not exercise an election separately from the IPA. Similarly, an election by a clinic to be exempt from the statutory limitations and restrictions or the failure of the clinic to elect to be exempt applies to costs of health care provided by any provider through the clinic. An individual provider may not exercise an election to be exempt separate from the clinic.

5. The statutory hold-harmless "opt-out" provision applies to physician services only if the services are provided under a contract with the HMO or if the physician is a selected provider for the HMO, unless the services are provided by a physician for a hospital, IPA or clinic which is subject to the statutory hold-harmless "opt-out" provision.

NOTICES

All notices of election and termination must be in writing and in accordance with rules promulgated by the Commissioner of Insurance. All

notices of election or termination filed with OCI are not affected by the renaming, reorganization, merger, consolidation or change in control of the provider, HMO, or other person. However, OCI may promulgate rules requiring an informational filing if any of these events occur.

Notices to the Office of the Commissioner of Insurance must be written, on the prescribed form, and received at the Office's current address:

P.O. Box 7873, Madison, WI 53707-7873

HMO CAPITAL AND SECURITY SURPLUS

Each HMO is required to meet minimum capital and surplus standards ("compulsory surplus requirements"). These standards are higher if the HMO has fewer than 90% of its liabilities covered by the statutory hold-harmless. Specifically, the compulsory surplus requirements are as follows:

1. From January 1, 1990, through December 31, 1990, at least the greater of $500,000 or 3% of the premiums earned by the HMO in the previous 12 months.
2. From January 1, 1991, through December 31, 1991, at least the greater of $500,000 or 4.5% of the premiums earned by the HMO in the previous 12 months if its covered liabilities are less than 90%, or 3% of the premiums earned by the HMO in the last 12 months if its covered liabilities are 90% or more.
3. Beginning January 1, 1992, at least the greater of $750,000 or 6% of the premiums earned by the HMO in the last 12 months if its covered liabilities are less than 90%, or 3% of the premiums earned by the HMO in the last 12 months if its covered liabilities are 90% or more.

In addition to capital and surplus, an HMO must also maintain a security surplus in the amount set by the Commissioner of Insurance.

FINANCIAL INFORMATION

An HMO is required to file financial statements with OCI. You may request financial statements from the HMO. OCI also maintains files of HMO financial statements which can be inspected by the public.

Ins 3.50 Appendix B

AUDITOR'S SPECIAL PROCEDURES REPORT ON THE SCHEDULE OF COVERED EXPENSES

Board of Directors
XYZ HMO

We have performed the following special procedures with respect to the Schedule of Covered Expenses for XYZ HMO for the year ended December 31, XXXX. It is understood that this report is solely to assist you in complying with s. Ins 3.50, Wis. Adm. Code, and ch. 609, Wis. Stats., and our report is not be used for any other purpose. Our procedures and findings are as follows:

a. A randomly selected sample was taken from all medical and hospital expenses paid during the calendar year to test the attribute that the expenses reported on the provider's IRS 1099-MISC forms (or other supporting documentation for providers not issued an IRS-1099-MISC form) trace to the Schedule of Covered Expenses for those providers included on the Schedule of Covered Expenses.

b. A comparison was made between the Schedule of Covered Expenses and the Election of Exemption notices by providers to verify that providers which had given notice of their Election of Exemption prior to December 31, XXXX, and which had not also given notice of their Termination of Election prior to December 31, XXXX, are excluded from the Schedule of Covered Expenses.

c. A review of the assumptions and methods of the HMO in establishing the amount of covered expenses included in the Incurred But Not Reported line of the Schedule of Covered Expenses was undertaken to determine if the company's estimate is reasonably estimated based on the HMO's historical data and best information available to the HMO.

Because the procedures do not constitute an examination made in accordance with generally accepted auditing standards, we do not express an opinion on any of the accounts or items referred to above. The following summarizes our findings as a result of the procedures referred to above.

FINDINGS REPORTED HERE

Had we performed any additional procedures, other matters might have come to our attention that would have been reported to you. This report relates only to the items specified above and does not extend to any financial statements of the HMO taken as a whole.

Date CPA Signature

Ins. 3.50 Appendix C

AUDITOR'S REPORT ON THE SCHEDULE OF COVERED EXPENSES

Date

BOARD OF DIRECTORS
XYZ Health Maintenance Organization

We have audited, in accordance with generally accepted auditing standards, Financial Statements of XYZ Health Maintenance Organization for the year ended December 31, XXXX, and have issued our report thereon dated XXXXXXXXX XX, XXXX. We have also audited the accompanying Schedule of Covered Expenses for XYZ Health Maintenance Organization as of December 31, XXXX. This schedule is the responsibility of management of XYZ Health Maintenance Organization. Our responsibility is to express an opinion on this schedule based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the aforementioned schedule is free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the aforementioned schedule. An audit also includes assessing the accounting principles used and any significant estimates made by management, as well as evaluating the overall schedule presentations. We believe that our audit provides reasonable basis for our opinion.

In our opinion, the schedule referred to above presents fairly, in all material respects, covered expenses for the year ended December 31, XXXX.

CPA Signature

Ins 3.51 Reports by individual practice associations. (1) DEFINITIONS. For the purpose of this section only:

(a) "Accountant" means an independent certified public accountant who is duly registered to practice and in good standing under the laws of this state or a state with similar licensing requirements.

(b) "Individual practice association" means an individual practice association as defined under s. 600.03 (23g), Stats., which contracts with a health maintenance organization insurer or a limited service health organization to provide health care services which are principally physician services.

(c) "Work papers" are the records kept by the accountant of the procedures followed, the tests performed, the information obtained, and conclusions reached pertinent to the examination of the financial statements of the independent practice association. Work papers include, but are not limited to, work programs, analysis, memorandum, letters of confirmation and representation, management letters, abstracts of company documents and schedules or commentaries prepared or obtained by the accountant in the course of the examination of the financial statements of the independent practice association and which support the accountant's opinion.

(2) FILING OF ANNUAL AUDITED FINANCIAL REPORTS. Unless otherwise ordered by the commissioner, an indiviual practice association shall file an annual audited financial report with the commissioner within 180 days after the end of each indiviual practice association's fiscal year. This section applies to individual practice associations for fiscal years terminating on or after March 31, 1991. The annual audited financial report shall report the assets, liabilities and net worth; the results of operations; and the changes in net worth for the fiscal year then ended on the accrual basis in conformity with generally accepted accounting practices. The annual audited financial report shall not be presented on the cash basis or the income tax basis or any other basis that does not fully account for all the independent practice association's liabilities incurred as of the end of the fiscal year. The annual audited financial report shall include all of the following:

(a) Report of independent certified public accountant.

(b) Balance sheet.

(c) Statement of gain or loss from opereations.

(d) Statement of changes in financial position.

(e) Statement of changes in net worth.

(f) Notes to the financial statements. These notes shall include those needed for fair presentation and disclosure.

(g) Supplemental data and information which the commissioner may from time to time require to be disclosed.

(3) SCOPE OF AUDIT AND REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT. Financial statements filed under sub. (2) shall be audited by an independent certified public accountant. The audit shall be conducted in accordance with generally accepted auditing standards. The commissioner may from time to time require that additional auditing

procedures be observed by the accountant in the audit of the financial statements of the independent practice association under this rule.

(4) AVAILABILITY AND MAINTENANCE OF CPA WORK PAPERS. (a) An independent practice association required to file an audited financial report under this rule shall, if requested by the office, require the accountant to make available to the office all the work papers prepared in the conduct of the audit. The independent practice association shall require that the accountant retain the audit work papers for a period of not less than 5 years after the period reported.

(b) The office may photocopy pertinent audit work papers. These copies are part of the office's work papers. Audit work papers are confidential unless the commissioner determines disclosure is necessary to carry out the functions of the office.

(5) CONTRACTS. A health maintenance organization insurer contracting with an independent practice association shall include provisions in the contract which are necessary to enable the individual practice association to comply with this section including, but not limited to:

(a) Provisions providing for timely access to records;

(b) Provisions providing for maintenance of necessary records and systems and segragation of records, accounts and assets; and

(c) Other provisions necessary to ensure that the individual practice association operates as an entity distinct from the insurer.

History: Cr. Register, August, 1990, No. 416, eff. 9-1-90.

Ins 3.52 Limited service health organizations. (1) PURPOSE. This section establishes financial and other standards for limited services 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. Subsections (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) "Complaint" means any dissatisfaction about an insurer or its contracted providers expressed by an enrollee.

(c) "Grievance" means any dissatisfaction with the administration or claims practices of or provision of services by a limited service health organization which is expressed in writing by or on behalf of a plan enrollee.

(a) "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 5 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 providers 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) A limited service health organization shall investigate each grievance pursuant to s. 609.15 (2), Stats. 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 or benefit, including a refusal to refer an enrollee, 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. The notification shall state the specific reason for the denial or initiation.

(c) A limited service health organization shall resolve all grievances within 30 calendar days of receiving the grievance. If the limited service health organization is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days if the limited service health organization notifies, in writing, the person who filed the grievance that the limited service health organization has not resolved the grievance, when resolution may be expected, and the reason for why additional time is needed.

(d) A grievance procedure shall include a method whereby the enrollee who made the grievance has the right to appear in person before the grievance committee to present written or oral information and to question those people responsible for making the determination which resulted in the grievance. The limited service health organization shall inform the enrollee in writing of the time and place of the meeting at least 7 calendar days before the meeting.

(e) Pars. (b), (c) and (d) do not apply in urgent care situations. Limited service health organizations shall develop a separate grievance procedure for urgent care situations. This procedure shall require a limited

service health organization to resolve an urgent care situation grievance within 4 business days of receiving the grievance.

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

(g) Limited service health organizations shall record, retain, and report records for each complaint and grievance with all of the following requirements:

1. Each limited service health organization shall keep and retain for at least a three-year period a record for each complaint and grievance submitted to the limited service health organization.

2. Each provider contract and administrative services agreement entered into between a limited service health organization and a provider shall contain a provision under which the provider must identify complaints and grievances and forward these complaints and grievances in a timely manner to the limited service health organization for recording and resolution.

3. Each limited service health organization shall submit a grievance experience report required by s. 609.15 (1) (c), Stats., to the commissioner by March 1 of each year. The report shall provide information on grievances received during the previous calendar year that were formally reviewed by a grievance panel of the limited service health organization. For purposes of this report, the limited service health organization shall classify each grievance as follows:

a. Plan administration. A grievance related to plan marketing, policyholder sevice, billing, underwriting, or similar administrative functions; or

b. Benefit denials. A grievance related to the denial of a benefit, including grievances related to refusals to refer enrollees or provide requested services.

4. Each limited service health organization shall keep together in a central location of the limited service health organization all records on complaints and grievances resolved before a formal review by a grievance panel is completed or in which the enrollee does not pursue a resolution. The limited service health organization shall make these records available for review during examinations by or on request of the commissioner.

(h) The commissioner shall by June 1 of each year prepare a report that summarizes grievance experience reports received by the commissioner from limited service health organizations. The report shall also summarize complaints involving limited service health organizations that were received by the office during the previous calendar year.

(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; renum. (3) (b) and (10) (c) to be (3) (d) and (10) (f), r. (10) (d), cr. (3) (b) and (c), (10) (c) to (e), (g) and (h), am. (10) (a) and (b), Register, October, 1989, No. 406, eff. 1-1-90; renum. from Ins 3.51, Register, August, 1990, No. 416, eff. 9-1-90.

Ins 3.53 HTLV-III antibody testing. (1) FINDINGS. The commissioner of insurance finds and designates that the series of HTLV-III antibody tests found by the state epidemiologist in a report entitled "Serologic tests for the presence of antibody to human T-lymphotropic virus type III" and dated July 28, 1986, to be medically significant and sufficiently

reliable for detecting the presence of the HTLV-III antibody is also sufficiently reliable for use in the underwriting of individual life, accident and health insurance. The state epidemiologist found that the combination of repeatedly reactive ELISA tests validated by a Western blot assay is highly predictive of a true infection with the HTLV-III virus, also known as the HIV or Human Immunodeficiency Virus. While this series of tests does not indicate that a person has AIDS, the use of this series for underwriting purposes is sufficiently reliable to indicate the presence of infection with the HTLV-III virus.

(2) PURPOSE. This section interprets s. 631.90 (3) (a), Stats., by designating which test or series of tests used to detect the HTLV-III antibody is sufficiently reliable for use in the underwriting of individual life, accident and health insurance policies.

(3) SCOPE. This section applies to any insurer writing individual life, accident and health insurance coverage in Wisconsin. Except as provided in sub. (6) (c), this section does not apply to any insurer writing group life, accident and health insurance coverage in Wisconsin, including group life, accident and health insurance coverage which is individually underwritten.

(4) DEFINITIONS. (a) "Alternate test site" means a human T-lymphotropic virus type III virus antibody counseling and testing facility designated by the state epidemiologist as an alternate test site.

(b) "ELISA" means an enzyme-linked immunosorbent assay serologic test which has been licensed by the federal food and drug administration.

(c) "Health care provider" has the meaning given under s. 146.81 (1), Stats.

(d) "Informed consent for testing or disclosure" has the meaning given under s. 146.025 (1) (d), Stats.

(e) "Informed consent for testing or disclosure form" has the meaning given under s. 146.025 (1) (e), Stats.

(f) "Medical information bureau, inc." means the non-profit Delaware incorporated trade association whose members are life insurance companies and which operates an information exchange on behalf of its members.

(g) "Positive ELISA test" means an ELISA test licensed by the federal food and drug administration, performed in accordance with the manufacturer's specifications and resulting in a single serum or plasma specimen which is reactive, both on an initial testing and on at least one of 2 additional tests of the same specimen.

Next page is numbered 164-11