CR 86-19

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

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Thomas P. Fox, Commissioner of Insurance and custodian of the official records of said office, do hereby certify that the annexed order creating a rule relating to Health Maintenance Organizations was issued by this office on May 9, 1986.

I further certify that said copy has been compared by me with the original on file in this office and that the same is a true copy thereof, and of the whole of such original.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name in the City of Madison, State of Wisconsin, this 9th day of May, 1986.

Thomas P. Fox
Commissioner of Insurance

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Revisor of Statutes Bureau

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DOUGLAS LA FOLLETTE
SECRETARY OF STATE

5-1-86

ORDER OF THE COMMISSIONER OF INSURANCE

CREATING A RULE

To create Ins 3.50 relating to health maintenance organizations.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

This rule interprets Chapter 609 and s. 601.41 (3), Stats. The purpose of this rule is to establish financial and other standards for health maintenance organizations doing business in Wisconsin. The financial requirements outlined in this rule include standards for minimum initial capital and surplus, operating funds, compulsory and security surplus and insolvency protection for enrollees. The rule outlines the information which must be included in a business plan filed by a health maintenance organization seeking to be licensed and establishes annual and quarterly reporting requirements.

The rule also describes the information which must be included in policies and certificates marketed by health maintenance organizations, establishes standards for grievance procedures, and describes permissible grounds for disenrolling members from the health maintenance organization.

Pursuant to the authority vested in the Office of the Commissioner of Insurance by s. 601.41 (3), Stats., the Office of the Commissioner of Insurance hereby creates a rule interpreting Chapter 609, Stats, as follows:

SECTION 1. Ins 3.50 is created to read:

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. Except for subsection (4), this section applies to all health maintenance organizations doing business in Wisconsin. Subsection (4) does not apply to health maintenance organizations operated as lines of business of licensed insurers unless the insurer does substantially all of its business as a health maintenance 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 at least a three-year term unless written notice of nonrenewal is given to the commissioner and the health maintenance organization at least 60 days prior to the renewal date.

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

(4) FINANCIAL REQUIREMENTS. (a) Minimum Capital or Minimum Permanent Surplus. The minimum capital or minimum permanent surplus for a health maintenance organization shall be at least $200,000.

(b) Compulsory Surplus. The health maintenance organization shall maintain a compulsory surplus to provide security against contingencies which 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 shall be equal to at least the greater of:

1. 3% of the premiums earned by the insurer in the previous twelve months; or

2. $200,000.

The commissioner may, by order, require a higher or lower compulsory surplus or may establish additional factors for determining the amount of compulsory surplus.

(c) Operating Funds. The health maintenance 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 health maintenance organization's capital or permanent surplus and 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 any other relevant information.

(d) Security Surplus. The health maintenance organization should maintain a security surplus to provide an ample margin of safety and clearly assure a sound operation. The security surplus of an 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 twelve months; or

2. 110% of its compulsory surplus.

(e) Deposit or Letter of Credit. Each health maintenance organization shall maintain either a deposit of securities with the state treasurer or an acceptable letter of credit in all periods in which policyholder surplus does not exceed $500,000. The amount of the deposit or letter of credit shall be at least $150,000. The letter of credit shall be

payable to the commissioner whenever rehabilitation or liquidation proceedings are initiated against the health maintenance organization.

(f) Insolvency Protection for Policyholders. Each health maintenance organization is required 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.

(g) Setting Greater Amounts. The commissioner may set greater amounts under (a), (c), (d), or (e) on finding that the financial stability of the organization requires it.

(h) Existing Insurers. For health maintenance organizations having a Certificate of Authority on the effective date of this rule, 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 shall include a proposed business plan. Health maintenance organizations subject to this section which are not separately licensed shall submit a proposed business plan prior to doing business as a health maintenance organization unless the commissioner waives this requirement. 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 organization, 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 plan. The summary shall include the potential number of enrollees in the operating territory, the projected number of enrollees for the first five 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, 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 organization.

(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 plan. 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) 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 in 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) (d) shall be filed under this section.

(7) COPIES OF PROVIDER AGREEMENTS. All health maintenance organizations subject to this section 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 health maintenance organization's administrative office and shall be made available to the commissioner on request.

(8) OTHER REPORTING REQUIREMENTS. (a) All separately licensed health maintenance organizations shall file with the commissioner by March 1 of each year an annual statement for the preceding year. The statement shall be on the current Health Maintenance Organization annual statement blank prepared by the National Association of Insurance Commissioners. All health maintenance organizations which are not separately licensed shall file an annual report in a form prescribed by the commissioner.

(b) A quarterly report, in a form prescribed by the commissioner, shall be filed within 45 days after the close of each of the first three quarters of the year unless the commissioner has notified the organization that another reporting schedule is appropriate.

(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 dependent children, alcoholism and other drug abuse, and nervous and mental disorders.

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

(b) In addition to the notice requirement under sub. (a), each time the health maintenance organization denies a claim or initiates disenrollment

proceedings, the health maintenance organization shall notify the affected enrollee of the right to file a grievance and the procedure to follow.

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

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

(11) OTHER NOTICE REQUIREMENTS. (a) Prior to enrolling members, the health maintenance organization shall provide to prospective group or individual policyholders information on the plan, including information on the services covered, a definition of emergency and out-of-area coverage, names and specific location of providers for each type of service, the cost of the plan, enrollment procedures, and limitations on benefits including limitations on choice of providers and the geographical area served 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 its 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. 227.0105, 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.

EFFECTIVE DATE. This section shall become effective 90 days after the first day of the month following its publication in the Wisconsin Administrative Register and shall apply to all policies issued or renewed after the effective date.

Dated at Madison, Wisconsin this 9th day of May, 1986.

Thomas P. Fox
Commissioner of Insurance

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05/06/86

The State of Wisconsin
Office of the Commissioner of Insurance

Thomas P. Fox
Commissioner
(608) 266-3585

DATE: May 9, 1986

TO: Gary Poulson

FROM: M. E. Van Cleave
Assistant Deputy Commissioner of Insurance

SUBJECT: Ins 3.50, Clearinghouse Number 86-19

Enclosed are two copies of an Order of the Commissioner of Insurance creating Ins 3.50, Clearinghouse Number 86-19 relating to Health Maintenance Organizations.

MEV:LH:jmr
Enclosure
1524J2

P.O. Box 7873 Madison, WI 53707