CR 86-111

STATE OF WISCONSIN
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SEP 25 1986

DOUGLAS LA FOLLETTE
SECRETARY OF STATE

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 limited service health organizations was issued by this office on September 25, 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 25th day of September, 1986.

Thomas P. Fox
Commissioner of Insurance

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SEP 25 1986
2:30 P.M.
Revisor of Statutes
Bureau

STATE OF WISCONSIN
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SEP 25 1986

DOUGLAS LA FOLLETTE
SECRETARY OF STATE

ORDER OF THE COMMISSIONER OF INSURANCE

CREATING A RULE

To create Ins 3.51 relating to limited service health 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 limited service health 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 limited service health 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 limited service health organizations, establishes standards for grievance procedures, and describes permissible grounds for disenrolling members from the limited service health organization.

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Limited service health organizations were created by 1985 Wisconsin Act 29. A limited service health organization is defined as "a health care plan . . . that makes available to its enrolled participants in consideration for periodic fixed payments, a limited range of health care services performed by providers selected by the organization."

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

SECTION 1. Ins 3.51 is created to read:

Ins 3.51 LIMITED SERVICE HEALTH ORGANIZATIONS

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

(2) SCOPE. Except for subs. (4) and (8), this section applies to all limited service health organizations doing business in Wisconsin. Subs. (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 three-year term unless written notice of nonrenewal is given to the commissioner and the limited service health organization at least 60 days prior to the renewal date.

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

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

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

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

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

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

b. $75,000.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

except that a limited service health organization may file a list of 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) Each limited service health organization shall develop an internal grievance procedure which shall be described in each policy and certificate issued to enrollees. Policies and certificates shall include a definition of a grievance.

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

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

(d) The limited service health 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 in a form prescribed by the commissioner.

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

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

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

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

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

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

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

5. The enrollee is unable to establish or maintain a satisfactory provider-patient relationship with the provider responsible for the enrollee's care. Disenrollment of an enrollee for this reason shall be permitted only if the limited service health organization can demonstrate that it provided the

enrollee with the opportunity to select an alternate primary care provider, made a reasonable effort to assist the enrollee in establishing a satisfactory provider-patient relationship and informed the enrollee that he or she may file a grievance on this matter.

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

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

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

EFFECTIVE DATE. This section shall become effective on the first day of the month following its publication in the Wisconsin Administrative Register as provided in s. 227.22 (2), Stats., except that it shall not apply to policies issued or renewed before January 1, 1987.

Dated at Madison, Wisconsin, this 25th day of September, 1986.

Thomas P. Fox
Commissioner of Insurance

126R12
09/19/86

The State of Wisconsin
Office of the Commissioner of Insurance

Thomas P. Fox
Commissioner
(608) 266-3585

DATE: September 25, 1986

TO: Gary Poulson

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

SUBJECT: Ins 3.51, Clearinghouse No. 86-111

Enclosed are two copies of an Order of the Commissioner of Insurance creating Ins 3.51, Clearinghouse No. 86-111 relating to limited service health organizations.

MEV:LH:sf
Enclosure
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