Chapter Ins 3

CASUALTY INSURANCE

Ins 3.01 Accumulation benefit riders attached to health and accident policies. Except where such rider is used only on a policy replacing the company's own policy, and so recites, no rider providing for accumulations of benefits will be approved for use upon any policy of health and accident insurance, whether it is proposed to issue such rider with or without an additional premium. Such rider operates as an aid to twisting the policies of another company in such manner as to make its use a direct encouragement of this practice.

Ins 3.02 Automobile fleets, vehicles not included in. Individually owned motor vehicles cannot be included or covered by fleet rates. The determining factor for inclusion under fleet coverage must be ownership and not management or use.

Ins 3.04 Dividends not deducted from premiums in computing loss reserves. Premiums returned to policyholders as dividends may not be

deducted from the earned premiums in computing loss reserves under s. 623.04, Stats.

History: 1-2-56; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.08 Municipal bond insurance. (1) PURPOSE. This section implements and interprets ss. 601.42, 611.19 (1), 618.21, 623.03, 623.04, 627.05, 628.34 (2), 632.14, and 632.17, Stats., for the purpose of establishing minimum requirements for the transaction of a type of surety insurance known as municipal bond insurance.

(2) SCOPE. This section shall apply to the underwriting, marketing, rating, accounting and reserving activities of insurers which write municipal bond insurance.

(3) DEFINITIONS. (a) "Annual statement" means the fire and casualty annual statement form specified in s. Ins. 7.01 (5) (a).

(b) "Contingency reserve" means a reserve established for the protection of policyholders covered by policies insuring municipal bonds against the effect of excessive losses occurring during adverse economic cycles.

(c) "Cumulative net liability" means one-third of one percent of the insured unpaid principal and insured unpaid interest covered by in-force policies of municipal bond insurance.

(d) "Municipal bonds" means securities which are issued by or on behalf of or are paid or guaranteed by:

1. Any state, territory or possession of the United States of America;

2. Any political subdivision of any such state, territory or possession; or

3. Any agency, authority or corporate or other instrumentality of any one or more of the foregoing, or which are guaranteed by any of the foregoing.

(e) "Municipal bond insurance" means a type of surety insurance authorized by s. Ins 6.75 (2) (g) which is limited to the guaranteeing of the performance and obligations of municipal bonds.

(f) "Municipal bond insurer" means an insurer which issues municipal bond insurance.

(g) "Total net liability" means the average annual amount due, net of reinsurance, for principal and interest on the insured amount of any one issue of municipal bonds.

(h) "Person" means any individual, corporation for profit or not for profit, association, partnership or any other legal entity.

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

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

(13) PRIMA FACIE MAXIMUM CREDIT ACCIDENT AND SICKNESS INSURANCE PREMIUM RATE STANDARDS. (a) If premiums are payable in one sum (single premium) for coverage for the entire duration of indebtedness, the premium rate standards for $100 of initial amount of insured indebtedness repayable in equal monthly instalments are shown below. Premium rate standards for other benefit plans and for indebtedness repayable in instalments other than as shown shall be actuarially consistent with the indicated rate standards, but no individual policy of credit accident and sickness insurance or group policy of credit accident and sickness insurance shall be delivered or issued for delivery if the benefits are payable after a waiting period of less than 14 days, regardless of whether the payment of benefits are retroactive to the first day of disability.

Original Number of Equal Monthly Instalments	14 days Non-Retroactive Elimination Period	30 Days
6	$1.39	$ .69
12	1.95	1.18
18	2.27	1.50
24	2.52	1.69
30	2.74	1.82
36	2.93	1.93
42	3.10	2.03
48	3.26	2.12
54	3.41	2.21
60	3.55	2.29
Basic permissable loss ratio	59%	52%

Original Number of Equal Monthly Instalments	14 Days Retroactive Waiting Period	30 Days
6	$1.74	$1.19
12	2.23	1.68
18	2.56	1.89
24	2.81	2.04
30	3.02	2.17
36	3.21	2.29
42	3.39	2.39
48	3.55	2.48
54	3.70	2.57
60	3.84	2.65
Basic permissible loss ratio	60%	57%

(b) The rate standards applicable for premiums payable on the basis of monthly outstanding balances shall be computed under the formula described in subd. 1 except as provided in subd. 2:

1. For credit accident and sickness insurance benefit plans issued on an individual or a group basis the premiums payable shall be computed as follows:

$$p_n = \frac{20\ P_n}{n + 1}$$

Where n = *Original* repayment period, in months

p_n = The Monthly Outstanding Balance Premium Rate per $1,000 for an indebtedness repayable in equal monthly instalments with an *original* repayment period of n months

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P_n = The Single Premium Rate per $100 initial insured indebtedness with an *original* repayment period of n months, from par. (a).

The outstanding balance premium rate for an indebtedness with a given original repayment period is applicable to the outstanding balance of this indebtedness at each month during the period, regardless of the remaining repayment period.

2. For credit accident and sickness insurance benefit plans issued on a group basis, a composite monthly outstanding balance premium rate schedule may be used in lieu of the rate procedure described in subd. 1 for each benefit plan, to apply to all outstanding balances each month under such plan, irrespective of the type or duration of loan making up such outstanding balances. Such composite monthly outstanding balance premium rate schedule will be approved for use only if the actuarial consistency of such composite rate with the prima facie maximum credit accident and sickness insurance premium rate standards and basic permissible loss ratios in par. (a) is established, and the reasons for this use in lieu of the rate standard in subd. 1 are documented.

3. The rate deviation procedure outlined in sub. (14) shall be applied separately to any business written under subd. 2 above, and the insurer shall maintain all pertinent data on such business separately.

(c) The rate standards set forth herein shall be applicable for a plan of benefits which contains:

1. No provision excluding or denying a claim for disability resulting from pre-existing conditions except for those conditions which manifested themselves to the insured debtor by requiring medical diagnosis or treatment or would have caused a reasonably prudent person to have sought the medical diagnosis or treatment, within 6 months preceding the effective date of the debtor's coverage and which caused loss within the 6 months following the effective date of coverage; provided, however, that disability commencing thereafter resulting from such condition shall be covered.

2. No other provision which excludes or restricts liability in the event of disability caused in a certain specified manner except that it may contain provisions excluding or restricting coverage in the event of pregnancy, intentionally self-inflicted injuries, foreign travel or residence, flight in non-scheduled aircraft, war or military service.

3. No age restrictions, or only age restrictions making ineligible for coverage:

a. Debtors less than age 18 at the time the indebtedness is incurred, or

b. Debtors age 65 or over at the time the indebtedness is incurred, or

c. Debtors who will have attained age 66 or over on the maturity date of the indebtedness.

4. Provision for a daily benefit equal in amount to the initial indebtedness divided by the number of days in the period during which the indebtedness is scheduled to be repaid in equal monthly instalments.

5. Provides for benefits to be payable in the event of disability resulting from bodily injury or sickness, which disability commences while the

debtor is insured hereunder and prevents the insured debtor from engaging in any gainful occupation for which he is reasonably qualified by reason of education, training or experience, except that during the initial 12 months of disability the inability of the insured to engage in his own occupation shall be the only test.

Note: This is not intended to preclude calculation of the daily benefit based on a 30 day month.

(d) The rate standards set forth in this subsection shall not apply for a plan of benefits wherein the aggregate of the periodic schedule of unpaid installments of indebtedness payable by credit accident and sickness insurance exceeds $10,000 or for which the term of the indebtedness insured exceeds 5 years.

(14) DEVIATION PROCEDURE AND CASE RATE DETERMINATION. (a) For cases of less than $50,000 earned premiums (prima facie basis) the case rates shall be the prima facie rates. For cases of $50,000 or greater earned premiums (prima facie basis) the actual case ratio shall be calculated as (actual ratio of claims incurred to premiums earned) divided by the basic permissible loss ratio shown in sub. (12) or (13). If the actual case ratio is within the acceptance range shown in the following credibility table, the case rates will be the prima facie rates. If the actual case ratio is outside the acceptance range, the adjusted case ratio will be calculated by adjusting the actual case ratio toward 100% by addition or subtraction of the "adjustment constant", also shown in the credibility table.

CREDIBILITY TABLE
Earned Premium (Prima Facie Basis)

Size Group	Small Loans or Credit Unions	Banks or Sales Finance	Acceptance Range	Adjustment Constant
CREDIT LIFE				
I	50,000-125,000	50,000- 200,000	0.80-1.20	0.15
II	125,000-300,000	200,000- 500,000	0.85-1.15	0.10
III	300,000-650,000	500,000-1,000,000	0.85-1.15	0.05
IV	650,000 or over	1,000,000 or over	0.90-1.10	0.00
CREDIT ACCIDENT AND SICKNESS				
I	50,000- 75,000	50,000- 100,000	0.80-1.20	0.15
II	75,000-125,000	100,000- 175,000	0.85-1.15	0.10
III	125,000-250,000	175,000- 350,000	0.85-1.15	0.05
IV	250,000 or over	350,000 or over	0.90-1.10	0.00

(b) If the adjusted case ratio exceeds 1.00, the case rate is the product of deviation factor f, and the prima facie rate shown in sub. (12) or (13), where

$f = [(\text{Adjusted case ratio} - 1) \times 1.25 \times \text{Basic Permissible Loss Ratio}] + 1$

(c) If the adjusted case ratio for credit accident and sickness insurance is less than 1.00, but greater than the limits specified in the following table, the case rates are the product of the deviation factor g, and the prima facie rates in sub. (13), where

$g = 1 - [(1 - \text{adjusted case ratio}) \times 1.25 \times \text{Basic Permissible Loss Ratio}]$

Plan of Benefit	*Limit*
14 days Retroactive Elimination Period	.55
14 days Non-Retroactive Elimination Period	.59
30 days Retroactive Elimination Period	.67
30 days Non-Retroactive Elimination Period	.89

$$\text{Limit} = \frac{.5\ (1\text{-}1.25 \times \text{Basic Permissible Loss Ratio})}{\text{Basic Permissible Loss Ratio}\ (1\text{-}.5 \times 1.25)}$$

(Rounded down)

(d) If the adjusted case ratio for credit accident and sickness insurance is less than 1.00, and less than or equal to the limit specified in the above table, the case rates are the product of the deviation factor h, and the prima facie rate in sub. (13) where
h = (Adjusted Case Ratio × Basic Permissible Loss Ratio × 2)

(e) If the adjusted case ratio for credit life insurance is less than 1.00, the case rate is the product of the deviation factor h and the prima facie rate in subsection (12) where

h = (Adjusted Case Ratio)

(f) If the case rate determined by the above procedures is within 5¢ of the existing single premium rate per $100 per year, the existing rate will be the case rate.

(g) The case rate as determined shall continue for a period equal to the experience period on which it was based. Where the case rate applies to a group of accounts, the rate will contiune to apply to every account which was grouped for determination of the rate and to only those accounts. The insurer shall annually determine and submit for filing under sub. (8) (a) the applicable case rate calculated as prescribed herein.

(h) As used in this rule the following words mean:

1. Account—The aggregate credit life or credit accident and sickness coverage for a single plan of benefits and class of business written through a single creditor by the insurer, whether coverage is written on a group or individual policy basis.

2. Class of business—Means any of the following:

a. Credit unions

b. Commercial and savings banks

c. Other cash loans (small loans, industrial bank loans, etc.)

d. Other sales finance (discount transactions, etc.)

3. Experience year—A 12-month period ending on the policy anniversary or renewal date or on a calendar year-end. Experience for a given account or permitted combinations of accounts shall be reported consistently from year to year.

4. Case—a. An account, if the earned premium for the account based upon the prima facie premium rates promulgated in sub. (12) or (13) during the most recent 3 experience years has been $50,000 or more. If the rates applicable to the account are not at the prima facie level or at a uniform percentage of the prima facie rates, the amount of premium

which would have been earned at the prima facie rates shall be approximated by a reasonable method filed with the experience report.

b. A combination of all the insurer's accounts of the same plan of benefits and class of business, excluding all accounts which meet the criterion for inclusion under a. immediately preceding.

5. Experience period—The last 3 experience years unless a lower number of full years produces an earned premium in size group IV as shown in the credibility table.

(j) In determining the case ratios in this subsection for application of the deviation formula, the following rules shall be applied:

1. If the coverage for a single creditor which qualifies for separate consideration under case definition a. above has been in force with the insurer for less than the experience period, the claim experience of the creditor while covered by any prior insurer shall be included to the extent necessary in determining the appropriate case ratios.

2. The case ratios shall be based wholly or partially on the experience of the insurer on the case whithin the state, or a group of states or on the total United States experience, so long as the insurer reports and files consistently for that case thereafter. An account which qualifies for separate treatment as a case but which provides coverage on a multi-state basis, may be considered in its entirety if the insurer so chooses excluding experience used for deviation purposes in any state, states or group of states.

(15) ACCOUNTING AND UNDERWRITING EXPERIENCE. Each insurer shall maintain records of premiums, losses and expenses of Wisconsin business separately for credit life insurance and credit accident and sickness insurance on a calendar year basis or on a policy year basis. Such underwriting experience shall be maintained for each form of policy, creditor, and class of creditor. This information shall be subject to call annually by the commissioner.

(16) FINANCIAL STATEMENT MINIMUM RESERVES. (a) Each insurer shall show, as a liability in any financial statement or report required under s. 601.42, Stats., its policy or unearned premium reserve in an amount not less than as computed in pars. (b), (c) and (d). If a credit insurance policy provides any combination of life insurance benefits, disability benefits and accident and sickness insurance benefits, a reserve must be established separately for the life insurance benefits, for the disability benefits and for the accident and sickness insurance benefits.

(b) The reserve for individual credit life insurance policies shall be not less than 130% of the Commissioner's 1958 Standard Ordinary Mortality Table at 3½% annual interest.

(c) The reserve for group credit life insurance policies shall be not less than 130% of the Commissioner's 1960 Standard Group Mortality Table at 3½% annual interest.

(d) The reserve for credit accident and sickness insurance policies and for disability benefits in credit life insurance policies shall be not less than the greater of 130% of the Commissioner's 1964 Disability Table at 3½% annual interest or the pro rata unearned premium reserve.

(17) SUBMISSION OF POLICY FORMS AND RATE SCHEDULES IN USE. Each insurer subject to this rule shall file with the commissioner on or before October 1, 1972, a listing of all policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders and the schedules of premium rates pertaining thereto which have been heretofore approved and which the insurer intends to issue or use in Wisconsin after the effective date of this rule.

(18) PENALTY. Violations of this rule shall subject the insurer or agent to s. 601.64, Stats.

Note: It is the intent of this rule that it shall apply prospectively to the review for approval of policy and other forms of credit life and credit accident and sickness insurance and to the rates applicable to such forms that are submitted for filing after the effective date. Individual hearings will be held to consider whether credit life and credit accident and sickness insurance contract forms and rate levels presently in use provide benefits that are reasonable in relation to premium charges.

History: Cr. Register, August, 1972, No. 200, eff. 9-1-72; cr. (2) (c), (6) (h) and (8) (h); am. (4) (b), (5), (8) (f), (12), (13) (a), (14) (e), and r. (17) (a), Register, February, 1973, No. 206, eff. 3-1-73; am. (4), (5), (6) (a) 6, (6) (h), (8) (f), (12) (g) 2, (13) (c) 3, (14) (c) and (d) and cr. (6) (i) and (13) (c) 5, Register, April, 1975, No. 232, eff. 5-1-75; am. (13) (b), Register, June, 1975, No. 234, eff. 7-1-75; emerg. am. (1) and (2), eff. 6-22-76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10-1-76; am. (4) and (11) (d), cr. (12) (h) and (13) (d), Register, March, 1977, No. 255, eff. 4-1-77; am. (1), (2) and (14) (c), Register, March, 1979, No. 279, eff. 4-1-79; am. (12) (b) to (e), Register, September, 1981, No. 309, eff. 10-1-81; r. (19) under s. 13.93 (2m) (b) 16, Stats., Register, December, 1984, No. 348; reprinted to correct printing errors in (13) (b), (14) (c) and (f), Register, June, 1986, No. 366.

Ins 3.26 Unfair trade practices in credit life and credit accident and sickness insurance. (1) PURPOSE. The purpose of this rule is to assist in the maintenance of a fair and equitable credit life insurance and credit accident and sickness insurance market. This rule interprets, including but not limited to, the following Wisconsin Statutes: 601.04; 601.01 (3) (a), (b), (c), (g) and (h); 601.41 (1), (2) and (3) and ch. 628.

(2) SCOPE. This rule shall apply to the transaction of credit life insurance as defined in s. Ins 6.75 (1) (a) 1. and 632.44 (3), Stats., and the transaction of credit accident and sickness insurance as defined in s. Ins 6.75 (1) (c) 1. or (2) (c) 1.

(3) UNFAIR TRADE PRACTICES DEFINED. The following acts, whether done directly or indirectly, in consideration of or in connection with a policy issued or proposed to be issued are defined to be prohibited unfair trade practices in the transaction of insurance described in sub. (2) above:

(a) The offer or grant by an insurer of any special favor or advantage, or any valuable consideration or inducement not set out in the insurance contract. The payment of agents' commissions, reported annually in Schedule 24S, shall not be a violation of this paragraph but the acts cited in pars. (b), (c), (d), (e) and (f) may not in any way be construed as agents' commissions.

(b) The offer to deposit or the deposit with a bank or other financial institution, money or securities of the insurer or of any affiliate of the insurer with the design or intent that the deposit offset or take the place of a deposit of money or securities which otherwise would be required of the creditor by such bank or financial institution as a compensating balance or offsetting deposit for a loan or other advancement.

(c) The deposit with a bank or other financial institution of money or securities without interest or at a lesser rate of interest than is currently

(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. Except for sub. (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 3-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 12 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 12 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 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 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 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, 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 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 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 3 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 par. (a), each time the health maintenance organization denies a claim or initiates disenrollment proceedings, the health maintenance organization shall notify the affected enrollee of the right to file a grievance and the procedure to follow.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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