Chapter Ins 3

CASUALTY INSURANCE

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

Ins 3.02 Automobile fleets, vehicles not included in. Individually owned motor vehicles cannot be included or covered by fleet rates. The deter-

mining factor for inclusion under fleet coverage must be ownership and not management or use.

Ins 3.04 Dividends not deducted from premiums in computing loss reserves. Premiums returned to policyholders as dividends may not be deducted from the earned premiums in computing loss reserves under s. 623.04, Stats.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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sioner 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.

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.

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.

(h) "Reactive" as used in par. (g) means a single serum or plasma specimen which has an absorbency that is greater than the manufacturer's recommended cut-off.

(i) "Reactive Western blot assay" means a Western blot assay performed in accordance with standard accepted procedures and resulting in a demonstration of antibody to any of the following proteins:

1. p24 and gp41 in the presence or absence of other bands.

2. p24 and p55 in the presence or absence of other bands.

3. gp41 in the presence or absence of other bands.

(j) "Western blot" means an assay which uses reagents consisting of HTLV-III antigens separated by polyacrylamide-gel electrophoresis which are then transferred to nitro-cellulose paper.

(5) HTLV-III ANTIBODY TESTING. A series of tests consisting of a positive ELISA test and a reactive Western blot assay is sufficiently reliable for use in the underwriting of individual life, accident and health insurance policies.

(6) HTLV-III ANTIBODY TEST RESULTS. (a) Except as provided in par. (b), an insurer may only disclose the results of a test for the presence of an antibody to HTLV-III to one or more of the following persons:

1. The applicant or insured who is tested.

2. The applicant's or insured's health care provider if the applicant or insured provides the insurer with informed consent for testing or disclosure to the health care provider.

3. Such other person as the applicant or insured authorizes through an informed consent for testing or disclosure.

(b) An insurer may disclose the results of a test for the presence of an antibody to HTLV-III to the medical information bureau, inc. only for a series of tests which result in a positive ELISA test and a reactive Western blot assay and only after receiving the informed consent for disclosure from the applicant or insured who undergoes the test. The informed consent for testing or disclosure form shall disclose that the test results may be sent to the medical information bureau, inc.

(c) An insurer may not use or obtain from any source including the medical information bureau, inc., the results of a test for the presence of an antibody to HTLV-III taken by any individual or information on whether a test for the presence of any antibody to HTLV-III has been obtained by any individual who is a member of a group for which the insurer is underwriting group life, accident and health insurance on an individual basis.

(d) An insurer may not require or request any individual to reveal whether the individual has undergone a test for the presence of an antibody to HTLV-III at an alternate test site or the results of such a test.

(e) An insurer which requires any individual to undergo a test for the presence of an antibody to HTLV-III shall provide the individual with an informed consent for testing or disclosure form prior to the time at which the individual undergoes the test. The insurer shall maintain a record of this consent.

(7) HTLV-III ANTIBODY TEST COSTS. An insurer may not require an applicant or insured to undergo a series of HTLV-III antibody tests unless the cost of such tests is borne by the insurer.

History: Cr. Register, May, 1987, No. 377, eff. 6-1-87.

Ins 3.54 Home health care benefits under disability insurance policies. (1) PURPOSE. This section implements and interprets ss. 628.34 (1) and (12), 631.20 and 632.895 (1) and (2), Stats., for the purpose of facilitating the administration of claims for coverage of home health care under disability insurance policies and the review of policy forms. The commissioner of insurance shall disapprove a policy under s. 631.20, Stats., if that policy does not meet the minimum requirements specified in this section.

(2) SCOPE. This section applies to disability insurance policies.

(3) DEFINITIONS. In this section:

(a) "Disability insurance policy" means a disability insurance policy as defined under s. 632.895 (1) (a), Stats., which provides coverage of expenses incurred for in-patient hosptial care.

(b) "Home health aide services" means nonmedical services performed by a home health aide which:

1. Are not required to be performed by a registered nurse or licensed practical nurse; and

2. Primarily aid the patient in performing normal activities of daily living.

(c) "Home care visits" means the period of a visit to provide home care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of home health aide services is one visit.

(d) "Medically necessary" means that the service or supply is:

1. Required to diagnose or treat an injury or sickness and shall be performed or prescribed by the physician;

2. Consistent with the diagnosis and treatment of the sickness or injury;

3. In accordance with generally accepted standards of medical practice; and

4. Not solely for the convenience of the insured or the physician.

(4) MINIMUM REQUIREMENTS. (a) All disability insurance policies including, but not limited to, medicare supplement or replacement policies, shall provide a minimum of 40 home care visits in a consecutive 12-month period for each person covered under the policy and shall make available coverage for supplemental home care visits as required by s. 632.895 (2) (e), Stats.

(b) An insurer shall review each home care claim under a disability insurance policy and may not deny coverage of a home care claim based solely on medicare's denial of benefits.

(c) An insurer may deny coverage of all or a portion of a home health aide service visit because the visit is not medically necessary, not appro-

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

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

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

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

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

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

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

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

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