APPENDIX I

INFORMATION SHEET ON CANCER INSURANCE

Cancer Insurance is Not a Substitute for Comprehensive Coverage.

Should You Buy Cancer Insurance?

Caution: Limitations On Cancer Insurance.

Prepared by the National Association of Insurance Commissioners

CANCER INSURANCE . . .

Cancer insurance is one of the fastest growing and most controversial forms of health insurance. It provides benefits only if you get cancer. No policy will cover cancer diagnosed before you applied for the policy. Examples of other specified disease policies are heart attack or stroke policies. The information in this booklet applies to cancer insurance, but could very well apply to other specified disease policies.

CANCER INSURANCE IS NOT A SUBSTITUTE FOR COMPREHENSIVE COVERAGE . . .

Cancer treatment accounts for less than 6% of U.S. health expenses. In fact, no single disease accounts for more than a small proportion of the American public's health care bill. This is why it is essential to have insurance coverage for all conditions, not just cancer.

If you and your family are not protected against catastrophic medical costs, you should consider a major medical policy. These policies pay a large percentage of your covered costs after a deductible is paid either by you or your basic insurance. They often have very high maximums, such as $100,000 to $1,000,000. Major medical policies will cover you for any accident or sickness, including cancer. They cost more than cancer policies, but they are generally considered a better buy.

SHOULD YOU BUY CANCER INSURANCE? . . . MANY PEOPLE DON'T NEED IT

If you are considering cancer insurance, ask yourself three questions: Is my current coverage adequate for these costs? How much will the treatment cost if I do get cancer? How likely am I to contract the disease? If you have Medicare and want more insurance, a comprehensive Medicare supplement policy is what you need.

Low income people who are Medicaid recipients don't need any more insurance. If you think you might qualify, contact your local social service agency.

Duplicate Coverage is Expensive and Unnecessary. Buy basic coverage first. Make sure any cancer policy will meet needs not met by your basic insurance. You cannot assume that double coverage will result in double benefits. Many cancer policies advertise that they will pay benefits no matter what your other insurance pays. However, your basic policy may contain a Coordination of Benefits clause. That means it will not pay duplicate benefits. To find out if you can get benefits from both policies, check your regular insurance as well as the cancer policy.

Some Cancer Expenses May Not Be Covered Even by a Cancer Policy. Medical costs of cancer treatment vary. On the average, hospitalization accounts for 78% of such costs and physician services make up 13%. The remainder goes for other professional services, drugs and nursing home care. For 1978, the average hospital cost for cancer treatment was $4,228. Cancer patients often face large nonmedical expenses which are not usually covered by cancer insurance. Examples are home care, transportation and rehabilitation costs.

Don't be Misled by Emotions. While one in four Americans will get cancer over a lifetime, three in four will not. In any one year, only one American in 285 will get cancer. The odds are against a Policyholder receiving any benefits.

CAUTION: LIMITATIONS OF CANCER INSURANCE . . .

Cancer policies sold today vary widely in cost and coverage. Contact different companies and agents, and compare the policies before you buy. Here are some common limitations:

Some policies pay only for hospital care. Today cancer care treatment, including radiation, chemotherapy and some surgery, is often given on an outpatient basis. Because the average stay in the hospital for a cancer patient is only 16 days, a policy which pays only when you are hospitalized has limited value.

Many policies promise to increase benefits after a patient has been in the hospital for 90 consecutive days. However, 99% of all cancer patients spend less than 60 days in the hospital. Large dollar amounts for extended benefits have very little value for most patients.

Many cancer insurance policies have fixed dollar limits. For example, a policy might pay only up to $1,500 for surgery costs or $1,000 for radiation therapy, or it may have fixed payments such as $50 or $100 for each day in the hospital. Others limit total benefits to a fixed amount such as $5,000 or $10,000.

No policy will cover cancer diagnosed before you applied for the policy. Some policies will deny coverage if you are later found to have had cancer at the time of purchase, even if you did not know it.

Most cancer insurance does not cover cancer-related illnesses. Cancer or its treatment may lead to other physical problems, such as infection, diabetes or pneumonia.

Many policies contain time limits. Some policies require waiting periods of 30 days or even several months before you are covered. Others stop paying benefits after a fixed period of two or three years.

FOR ADDITIONAL HELP . . .

If you are considering a cancer policy, the company or agent should answer your questions. If you do not get the information you want, discuss the matter with your State Insurance Department.

Ins 3.48 Preferred provider plans. (1) SCOPE. This section applies to all preferred provider plans as defined in s. 609.01 (4), Stats.

(2) DEFINITIONS. In this section:

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

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

(3) EXCESSIVE DISTANCES. (a) Except as provided in pars. (b) and (c), preferrd provider plans shall offer coverage to a person only if preferred providers of primary care services and emergency services are available within 30 minutes' travel time of the person's place of residence.

(b) A preferred provider plan may offer coverage on a group basis to an employer for its employes or to an employe organization without taking into account the places of residence of the employes, if preferred providers of primary care services and emergency services are available either within the county or within 30 minutes' travel time of the employment location.

(c) A preferred provider plan may provide coverage to a person without taking into account the person's place of residence or employment if the person is informed in writing of the services covered and the location of all preferred providers and makes a written request for coverage.

(4) CONTINUITY OF PATIENT CARE. (a) Subject to pars. (b), (c), (d) and (e), a preferred provider plan which is offered on a group basis to an employer for its employes or to an employe organization shall extend enrollment periods for group members and their families who wish to be enrolled in the plan, but who are in a course of treatment with a provider not selected by the plan and wish to continue that course of treatment. Enrollment standards for those who request an extended enrollment period shall be no more restrictive than they are for those who enroll during the normal enrollment period.

(b) A preferred provider plan may require a group member to request an extended enrollment period during the normal enrollment period specified by the plan and to indicate the nature and the expected duration of the course of treatment.

(c) A preferred provider plan is not required to extend enrollment opportunities to a dependent of a group member unless the group member and any other dependents also receive an extension.

(d) A preferred provider plan may limit the extension of the enrollment period for a group member and dependents to 90 days after the effective date of the contract.

(e) A preferred provider plan shall receive no premiums and bear no responsibility for coverage of group members and their dependents until they are enrolled.

(f) When a person changes from one plan to another, the responsibilities of the prior and succeeding insurers outlined in s. Ins 6.51 (6), (7) and (8) shall apply.

(5) SUBSTANTIALLY EQUIVALENT BENEFITS DEFINED. (a) For purposes of s. 609.10 (1) (a), Stats., plans will be considered to provide substantially equivalent benefits if they offer comparable coverage for the following services: hospital room and board, other inpatient hospital services,

surgery, home and office physician services, inhospital physician care, x-ray and laboratory services.

(b) Notwithstanding par. (a), plans providing substantially equivalent benefits may differ as to premium, deductible, coinsurance, benefit maximum provisons and limitations on choice of providers.

(c) Plans providing substantially equivalent benefits may differ in their coverage of services other than those listed in par. (a).

(6) ADEQUATE NOTICE. (a) Preferred provider plans shall provide to policyholders information on the plan, including information on the services covered; a definition of emergency services if emergency services are covered differently than other services; the specific location of providers for each type of service; the cost of the plan; enrollment procedures; limitations on benefits, including limitations or requirements imposed by an institutional provider because of its affiliation with a religious organization; and restrictions on choice of providers. This information shall be provided to employers at least 30 days before the first day of each enrollment period. The preferred provider plans shall ensure that employers make this information available to all prospective certificate holders in time for them to make an informed choice among available plans. If a preferred provider plan is offered on an individual basis, the information shall be given at the time of application.

(b) The information provided shall be legible, complete, understandable, presented in a meaningful sequence, contain a single section listing exclusions and limitations and define words and expressions which are not commonly understood or whose commonly understood meaning is not intended.

(c) The information provided shall meet the standards for an invitation to apply set forth in s. Ins 3.27.

(7) GRIEVANCE PROCEDURE. (a) A preferred provider plan shall investigate each grievance pursuant to s. 609.15 (2), Stats. Each preferred provider plan shall develop an internal grievance procedure and shall describe the grievance procedure 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 preferred provider plan denies a claim or benefit, including a refusal to refer an enrollee, or initiates disenrollment proceedings, the preferred provider plan shall notify the affected enrollee of the right to file a grievance and the procedure to follow. The notification shall state the specific reason for the denial or initiation.

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

(d) A grievance procedure shall include a method whereby the enrollee who made the grievance has the right to appear in person before the grievance committee to present written or oral information and to ques-

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) DEFINITIONS. In this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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) A health maintenance organization shall investigate each grievance pursuant to s. 609.15 (2), Stats. Each health maintenance organization shall develop an internal grievance procedure which shall be described in each policy and certificate issued to enrollees. Policies and certificates shall include a definition of a grievance.

(b) In addition to the notice requirement under par. (a), each time the health maintenance organization denies a claim or benefit, including a refusal to refer an enrollee, or initiates disenrollment proceedings, the health maintenance organization shall notify the affected enrollee of the right to file a grievance and the procedure to follow. The notification shall state the specific reason for the denial or initiation.

(c) The health maintenance organization shall resolve all grievances within 30 calendar days of receiving the grievance. If the health maintenance organization is unable to resolve the grievance within 30 calendar

days, the time period may be extended an additional 30 calendar days if the health maintenance organization notifies, in writing, the person who filed the grievance that the health maintenance organization has not resolved the grievance, when resolution may be expected, and the reason for why additional time is needed.

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

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

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

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

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

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

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

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

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

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

The health maintenance organization shall make these records available for review during examinations by or on request of the commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History: Cr. Register, June, 1986, No. 366, eff. 9-29-86; renum. (3) (b) and (10) (c) to be (3) (d) and (10) (f), r. (10) (d), cr. (3) (b) and (c), (10) (c) to (e), (g) and (h), am. (10) (a) and (b), Register, October, 1989, No. 406, eff. 1-1-90.

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. Subsections (4) and (8) do not apply to a limited service health organization operated as a line of business of a licensed insurer unless the insurer does substantially all of its business as a limited service health organization.

(3) DEFINITIONS. (a) "Acceptable letter of credit" means a clean, unconditional, irrevocable letter of credit issued by a Wisconsin bank or any other financial institution acceptable to the commissioner which renews on an annual basis for a 3-year term unless written notice of nonrenewal is given to the commissioner and the limited service health organization at least 60 days prior to the renewal date.

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

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

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

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

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

to the commissioner whenever rehabilitation or liquidation proceedings are initiated against the limited service health organization.

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

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

a. 3% of the premiums earned by the limited service health organization in the previous 12 months; or

b. $75,000.

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

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

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

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

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

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

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

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

(c) *Feasibility study.* A feasibility study which supports the financial and enrollment projections of the plan, including the potential number of enrollees in the geographical service area, the estimated number of enrollees for the first 5 years, the underwriting standards to be applied, and the method of marketing the organization.

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

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

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

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

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

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

2. A summary of how the limited service health organization will provide administrative services, including size and qualifications of the administrative staff, and the projected cost of administration in relation to premium income shall accompany the application if a limited service health organization provides its own administrative services and does

not delegate these functions to a person or organization outside of the limited service health organization.

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

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

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

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

(7) PROVIDER AGREEMENTS. (a) Prior to doing business, all limited service health organizations shall file with the commissioner copies of all executed provider agreements and other contracts covering its liabilities except that a limited service health organization may file a list of providers executing a standard contract and a copy of the form of the contract instead of copies of the individual executed contracts.

(b) A limited service health organization shall maintain executed copies of all provider agreements in its administrative office and shall make the copies available to the commissioner on request.

(8) OTHER REPORTING REQUIREMENTS. (a) A limited service health organization shall file an annual statement for the preceding year with the commissioner by March 1 of each year and shall put the statement on the current health maintenance organization annual statement blank prepared by the national association of insurance commissioners.

(b) The commissioner may require other reports on a regular or other basis as appropriate.

(9) POLICY AND CERTIFICATE LANGUAGE REQUIREMENTS. Each policy form marketed by a limited service health organization and each certificate given to enrollees shall contain:

(a) A definition of geographical service area, emergency care, urgent care, out-of-area services, dependents and primary provider, if these terms or terms of similar meaning are used in the policy or certificate and have an effect on the benefits covered by the plan. The definition of geo-

graphical service area need not be stated in the text of the policy or certificate if the definition is adequately described in an attachment which is given to all enrollees along with the policy or certificate.

(b) Clear disclosure in the exclusions, limitations, and exceptions section of any provision which limits benefits or access to service. The exclusions, limitations and exceptions which shall be disclosed include those relating to emergency and urgent care, restrictions on the selection of primary or referral providers, restrictions on changing providers during the contract period, out-of-pocket costs including copayments and deductibles, charges for missed appointments or other administrative sanctions, restrictions on access to care if copayments or other charges are not paid, and any restrictions on coverage for dependents who do not reside in the service area.

(10) GRIEVANCE PROCEDURE. (a) A limited service health organization shall investigate each grievance pursuant to s. 609.15 (2), Stats. Each limited service health organization shall develop an internal grievance procedure which shall be described in each policy and certificate issued to enrollees. Policies and certificates shall include a definition of a grievance.

(b) In addition to the notice requirement in par. (a), each time the limited service health organization denies a claim or benefit, including a refusal to refer an enrollee, and each time it initiates disenrollment proceedings under sub. (12) (b) 5, the limited service health organization shall notify the affected enrollee of the right to file a grievance and the procedure to follow. The notification shall state the specific reason for the denial or initiation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Note: Section Ins 3.51 shall not apply to policies issued or renewed before January 1, 1987.

History: Cr. Register, November, 1986, No. 371, eff. 12-1-86; renum. (3) (b) and (10) (c) to be (3) (d) and (10) (f), r. (10) (d), cr. (3) (b) and (c), (10) (c) to (e), (g) and (h), am. (10) (a) and (b), Register, October, 1989, No. 406, eff. 1-1-90.

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.

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