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.

5. Home care benefits of 40 visits per 12-month period as required under s. 632.895 (1) and (2), Stats., and s. Ins 3.54;

6. Nursing home confinement, kidney disease treatment, and diabetes expense coverage as required under s. 632.895 (3), (4) and (6), Stats.;

7. In group policies, nervous and mental disorder and alcoholism and other drug abuse coverage as required under s. 632.89, Stats.; and

8. Chiropractic coverage as required under s. 632.87, Stats.

(d) The availability of an approved Medicare supplement insurance policy. Each insurer which markets a Medicare replacement policy shall have an approved Medicare supplement insurance policy available for all currently enrolled participants at such time as the direct risk contract between the Health Care Financing Administration and the insurer is terminated.

(8) PERMISSIBLE MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY OR CERTIFICATE EXCLUSIONS AND LIMITATIONS. (a) The coverage set out in subs. (5) and (7):

1. May exclude expenses for which the insured is compensated by Medicare;

2. May contain an appropriate provision relating to the effect of other insurance on claims;

3. May contain a pre-existing condition waiting period provision as provided in sub. (4) (a) 2., which shall appear as a separate paragraph of the policy and shall be captioned or titled "Pre-existing Condition Limitations"; and

4. May, if issued by a health maintenance organization as defined by s. 609.01 (2), Stats., include territorial limitations which are generally applicable to all coverage issued by the plan.

(b) If the insured chooses not to enroll in Medicare Part B, the insurer may exclude from coverage the expenses which Medicare Part B would have covered if the insured were enrolled in Medicare Part B. An insurer may not exclude Medicare Part B approved expenses incurred beyond what Medicare Part B would cover.

(c) The coverages set out in subs. (5) and (7) may not exclude, limit, or reduce coverage for specifically named or described pre-existing diseases or physical conditions, except as provided in par. (a) 3.

(e) A Medicare replacement policy and Medicare supplement policy may include other exclusions and limitations which are not otherwise prohibited and are not more restrictive than exclusions and limitations contained in Medicare.

(9) INDIVIDUAL POLICIES PROVIDING NURSING HOME, HOSPITAL CONFINEMENT INDEMNITY, SPECIFIED DISEASE AND OTHER COVERAGES. (a) *Caption requirements.* Captions required by this subsection shall be:

1. Printed and conspicuously placed on the first page of the Outline of Coverage,

2. Printed on a separate form attached to the first page of the policy, and

3. Printed in 18-point bold letters.

(c) *Hospital confinement indemnity coverage.* An individual policy form providing hospital confinement indemnity coverage sold to a Medicare eligible person:

1. Shall not include benefits for nursing home confinement unless the nursing home coverage meets the standards set forth in s. Ins 3.46;

2. Shall bear the caption, if the policy provides no other types of coverage: "This policy is not designed to fill the gaps in Medicare. It will pay you only a fixed dollar amount per day when you are confined to a hospital. For more information, see 'Health Insurance Advice for Senior Citizens', given to you when you applied for this policy."

3. Shall bear the caption set forth in par. (e), if the policy provides other types of coverage in addition to the hospital confinement indemnity coverage.

(d) *Specified disease coverage.* An individual policy form providing benefits only for one or more specified diseases sold to a Medicare eligible person shall bear:

1. The designation: SPECIFIED OR RARE DISEASE LIMITED POLICY, and

2. The caption: "This policy covers only one or more specified or rare illnesses. It is not a substitute for a broader policy which would generally cover any illness or injury. For more information, see 'Health Insurance Advice for Senior Citizens', given to you when you applied for this policy."

(e) *Other coverage.* An individual disability policy sold to a Medicare eligible person, other than a form subject to sub. (5) or (7) or otherwise subject to the caption requirements in this subsection or exempted by sub. (2) (d) or (e), shall bear the caption: "This policy is not a Medicare supplement. For more information, see 'Health Insurance Advice for Senior Citizens', given to you when you applied for this policy."

(10) CONVERSION OR CONTINUATION OF COVERAGE. (a) Conversion requirements. An insured under individual, family, or group hospital or medical coverage who will become eligible for Medicare and is offered a conversion policy which is not subject to subs. (4) and (5) or (7) shall be furnished by the insurer, at the time the conversion application is furnished in the case of individual or family coverage or within 14 days of a request in the case of group coverage:

1. An outline of coverage as described in par. (d) and

2. A copy of the current edition of the pamphlet described in sub. (11).

(b) Continuation requirements. An insured under individual, family, or group hospital or medical coverage who will become eligible for Medi-

2. At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy for the time specified in s. 632.897, Stats.

(c) If a group Medicare supplement policy is replaced by another group Medicare supplement policy, the suceeding insurer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any limitation for pre-existing conditions that would have been covered under the group policy being replaced.

Note: This rule requires the use of a rate change transmittal form which may be obtained from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, WI 53707-7873.

History: Cr. Register, July, 1977, No. 259, eff. 11-29-77; am. (13), Register, September, 1977, No. 261, eff. 1-1-78; am. (2), (3) (d), (4) (a) 1., (4) (b) 1. a., 3. e. and 4., (5) (a) 3. a., (5) (b) 3. intro., 3. a., 3. b., (5) (c) 3. a. and b., (5) (d) 3. a., (5) (e) 3. intro. and a., r. and recr. (4) (b) 5., (6), (7), (8) and (9), r. (10), renum. (11) to (13) to be (10) to (12), cr. (4) (b) 6. and 7., Register, December, 1978, No. 276, eff. 1-1-79; am. (4) (b) 1.a., (5) (a) 2. and (b) 2., (5) (c) 2. and (9), r. (5) (d) and (e), Register, April, 1981, No. 304, eff. 5-1-81; r. and recr. (7) (b), Register, May, 1981, No. 305, eff. 6-1-81; r. and recr. Register, June, 1982, No. 318, eff. 7-1-82; renum. (4) (a) 9. to be 10., cr. (4) (a) 9., am. (5) (intro.) and (6) (a) 6., Register, October, 1984, No. 346, eff. 11-1-84; r. (12) under s. 13.93 (2m) (b) 16, Stats., Register, December, 1984, No. 348; am. (1) (a) to (c), (2) (a) (intro.), 1. and 2., (3) (b) and (d), (4) (intro.), (a) 5., 8. and 9., (c) 5., (5) (intro.), (a) 2., (b) 2. and (c) 2., (6) (a) 2. and 3., (9), (11) and Appendix, cr. (3) (dm), (5) (d) and (6) (e), r. (13), Register, November, 1985, No. 359, eff. 1-1-86; cr. (5) (a) 3. i., (b) 3. f., (c) 3. e. and (d) 3. g. Register, April, 1987, No. 376, eff. 6-1-87; emerg. r. and recr. eff. 9-30-88; r. and recr. Register, February, 1989, No. 398, eff. 3-1-89; emerg. r. (5) (d) to (h), (8) (d), renum. (3) (a) to be (3) (am), am. (2) (a) 3., (4) (a) 3. and 7., (b) 5., (d), (e) 1. and 5., (g), (5) (c) (intro.), 4. and 5., (i) 4. and 5., (6) (intro.) and (b), (7) (c) 4. and 5., (8) (a) 1. and (e), (9) (e), (10) (a) (intro.) and (d) 2., (11) and (14), r. and recr. (4) (b) 7., and Appendix, cr. (3) (a), (4) (a) 14. and (f), (5) (c) 6. to 10. and (i) 7., (7) (c) 6. to 8. and (d), (15) and (16), Appendix 2 and 3, eff. 12-11-89, except Appendices eff. 1-1-90; emerg. cr. (17) to (19) and am. (5) (c) 4., eff. 1-2-90; r. (5) (d) to (h) and (8) (d), renum. (3) (a) to be (3) (am), am. (2) (a) 3., (4) (a) 2., 3. and 7., (b) 5., (d), (e) 1. and 5., (g) (5) (b), (c) (intro.), 2., 4. and 5., (i) 4. and 5., (6) (intro.) and (b), (7) (c) 4. and 5., (8) (a) 1. and (e), (9) (e), (10) (a) (intro.) and (d) 2., (11) and (14), r. and recr. (4) (b) 7. and Appendices, cr. (3) (a), (4) (a) 14. and (f), (5) (c) 6. to 12. and (i) 7., (7) (c) 6. to 8. and (d), (15) to (28), Appendices 2 to 6, Register, July, 1990, No. 415, eff. 8-1-90; emerg. cr. (3) (af) to (aj), (bl), (gl), (gm), (il), (im), (14) (a), (16) (d) and (29), r. and recr. (3) (c), am. (3) (d), (4) (a) 3. and 5., (e), (5) (c) 2., (7) (c) 3., (8) (a) 3., (16) (a) and (b), (21) (a) to (c), (23) (c) and (d), renum. (14) (intro.) to be (14) (b), eff. 1-1-91; r. (9) (b), Register, April, 1991, No. 424, eff. 6-1-91.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Note: The last paragraph may be omitted if the Plan provides only one benefit or may be altered to suit the coverage provided.

ALTERNATIVE 2.

(B) *Reduction in This Plan's Benefits.* The benefits of This Plan will be reduced when the sum of:

(i) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

(ii) the benefits that would be payable for the Allowable Expenses under the other Plans in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made,

exceeds the greater of (a) 80% of those Allowable Expenses or (b) the amount of the benefits in (i) above. In that case, the benefits of This Plan will be reduced so that they and the benefits in (ii) above do not total more than the greater of that (a) and (b).

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan."

ALTERNATIVE 3

(B) REDUCTION IN THIS PLAN'S BENEFITS. The benefits that would be payable under This Plan in the absence of this COB provision will be reduced by the benefits payable under the other Plans for the expenses covered in whole or in part under This Plan. This applies whether or not claim is made under a Plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an expense incurred and a benefit payable.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan."

(V) RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these COB rules. The [name of insurance company] has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The [name of insurance company] need not tell or get the consent of any person to do this. Each person claiming benefits under This Plan must give the [name of insurance company] any facts it needs to pay the claim.

(VI) FACILITY OF PAYMENT.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, The [name of insurance company] may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The [name of insurance company] will not have to

pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

(VII) RIGHT OF RECOVERY.

If the amount of the payments made by the [name of insurance company] is more than it should have paid under this COB provision, it may recover the excess from one or more of:

(A) the persons it has paid or for whom it has paid;

(B) insurance companies; or

(C) other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Ins 3.41 Individual conversion policies. (1) REASONABLY SIMILAR COVERAGE. An insurer provides reasonably similar coverage under s. 632.897 (4), Stats., to a terminated insured as defined in s. 632.897 (1) (f), Stats., if a person is offered individual coverage substantially identical to the terminated coverage under the group policy or individual policy, or is offered his or her choice of the 3 plans described in s. Ins 3.42, or is offered a high limit comprehensive plan of benefits approved for the purpose of conversion by the commissioner as meeting the standards described in s. Ins 3.43. Individual conversion policies must include benefits required for individual disability insurance policies by subch. VI, ch. 632, Stats. This subsection does not apply to a long-term care policy as defined under s. Ins 3.46 (3) (e).

(2) RENEWABILITY. (a) Except as provided in par. (b), individual conversion policies shall be renewable at the option of the insured unless the insured fails to make timely payment of a required premium amount, there is over-insurance as provided by s. 632.897 (4) (d), Stats., or there was fraud or material misrepresentation in applying for any benefit under the policy.

(b) Conversion policies issued to a former spouse under s. 632.897 (9) (b), Stats., must include renewal provisions at least as favorable to the insured as did the previous coverage.

(3) PREMIUM RATES. (a) In determining the rates for the class of risks to be covered under individual conversion policies, the premium and loss experience of policies issued to meet the requirements of s. 632.897 (4), Stats., may be considered in determining the table of premium rates applicable to the age and class of risks of each person to be covered under the policy and to the type and amount of coverage provided.

(b) Except as provided in par. (c), conditions pertaining to health shall not be an acceptable basis for classification of risks.

(c) A conversion policy issued to a former spouse under s. 632.897 (9) (b), Stats., may be rated on the basis of a health condition if a similar rating had been previously applied to the prior individual coverage due to the same condition.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81; am. (1), Register, April, 1991, No. 424, eff. 6-1-91.

Ins 3.42 Plans of conversion coverage. Pursuant to s. 632.897 (4) (b), Stats., the following plans of conversion coverage are established.

(1) *Plan 1—Basic Coverage*— Plan 1 basic coverage consists of the following:

(a) Hospital room and board daily expense benefits in a maximum dollar amount approximating the average semi-private rate charged in the major metropolitan area of this state, for a maximum duration of 70 days per calendar year;

(b) Miscellaneous in-hospital expenses, including anesthesia services, up to a maximum amount of 20 times the hospital room and board daily expense benefits per calendar year; and

(c) In-hospital and out-of-hospital surgical expenses payable on a usual, customary and reasonable basis up to a maximum benefit of $2,000 a calendar year.

(2) *Plan 2—Major Medical Expense Coverage*— Plan 2 major medical expense coverage shall consist of benefits for hospital, surgical and medical expenses incurred either in or out of a hospital of the following:

(a) A lifetime maximum benefit of $75,000.

(b) Payment of benefits at the rate of 80% of covered hospital, medical, and surgical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits shall be paid at 100% for the remainder of the benefit period; provided, however, benefits for outpatient treatment of mental illness, if covered by the policy, may be limited as provided in par. (g), and surgical expenses shall be covered at a usual, customary and reasonable level.

(c) A deductible for each benefit period of $500 except that the deductible shall be $1,000 for each benefit period for a policy insuring members of a family. All covered expenses of any insured family member may be applied to satisfy the deductible.

(d) A "benefit period" shall be defined as a calendar year.

(e) Payment for all services covered under the contract by any licensed health care professional qualified to provide the services; except payment for psychologists' services may be conditioned upon referral or supervision by a physician.

(f) Payment of benefits for maternity, subject to the limitations in pars. (a),(b), and (c), if maternity was covered under the prior policy.

(g) Benefits for outpatient treatment of mental illness, if provided by the policy, may be limited to either of the following coverages at the option of the insurer:

1. At least 50% of usual, customary and reasonable expenses which are in excess of the policy deductible, subject to the policy lifetime maximum.

2. The minimum benefits for group policies described in s. 632.89 (2) (d), Stats.

(3) *Plan 3—Major Medical Expense Coverage*— Plan 3 major medical expense coverage shall consist of benefits for hospital, surgical and medical expenses incurred either in or out of a hospital of the following:

(Same as Plan 2 except that maximum benefit is $100,000 and deductible is $1,000 for an individual and $2,000 for a family.)

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81; am. (2) (b) and (e), cr. (2) (f) and (g), Register, October, 1982, No. 322, eff. 11-1-82.

Ins 3.43 High limit comprehensive plan of benefits. (1) A policy form providing a high limit comprehensive plan of benefits may be approved as an individual conversion policy as provided by s. 632.897 (4) (b), Stats., if it provides comprehensive coverage of expenses of hospital, surgical and medical services of not less than the following:

(a) A lifetime maximum benefit of $250,000.

(b) Payment of benefits at the rate of 80% of covered hospital, medical, and surgical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits shall be paid at 100% for the remainder of the benefit period; provided, however, benefits for outpatient treatment of mental illness, if covered by the policy, may be limited as provided in par. (g), and surgical expenses shall be covered at a usual, customary and reasonable level.

(c) A deductible for each benefit period of at least $250 and not more than $500 except that the deductible shall be at least $250 and not more than $1,000 for each benefit period for a policy insuring members of a family. All covered expenses of any insured family member may be applied to satisfy the deductible.

(d) A "benefit period" shall be defined as a calendar year.

(e) Payment for all services covered under the contract by any licensed health care professional qualified to provide the services; except payment for psychologists' services may be conditioned upon referral or supervision by a physician.

(f) Payment of benefits for maternity, subject to the limitations in pars. (a),(b), and (c), if maternity was covered under the prior policy.

(g) Benefits for outpatient treatment of mental illness, if provided by the policy, may be limited to either of the following coverages at the option of the insurer:

1. At least 50% of usual, customary and reasonable expenses which are in excess of the policy deductible, subject to the policy lifetime maximum.

2. The minimum benefits for group policies described in s. 632.89 (2) (d), Stats.

(2) The filing procedures of s. Ins 3.12, shall apply to policy forms filed as individual conversion policies.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81; am. (1) (b) and (e), cr. (1) (f) and (g), Register, October, 1982, No. 322, eff. 11-1-82.

Ins 3.44 Effective date of s. 632.897, Stats. (1) Section 632.897, Stats., applies to group policies issued or renewed on or after May 14, 1980, or if

a policy is not renewed within 2 years after the effective date of the act, s. 632.897, Stats., is effective at the end of 2 years from May 14, 1980.

(2) (a) A group policy as defined in s. 632.897 (1) (c) 1 or 3 shall be considered to have been renewed on any date specified in the policy as a renewal date or on any date on which the insurer or the insured changed the rate of premium for the group policy.

(b) A group policy as defined in s. 632.897 (1) (c) 2 shall be considered to have been renewed on any date on which an underlying collective bargaining agreement or other underlying contract is renewed, or on which a significant change is made in benefits.

(3) Section 632.897, Stats., applies to individual policies issued or renewed after May 14, 1980, except that it shall not apply to any individual policy in force on May 13, 1980, in which the insurer does not have the option of changing premiums.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.45 Conversion policies by insurers offering group policies only. Section 632.897 (4) (d) (first sentence), Stats., establishes that an insurer offering group policies only is not required to offer individual coverage. Since the insurer has no individual conversion policies which it may offer, it may not require a terminated insured who elected to continue coverage under s. 632.897 (2), Stats., to convert to individual coverage under s. 632.897 (6), Stats., after 12 months. The terminated person may continue group coverage except as provided in s. 632.897 (3) (a), Stats.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.455 Long-term care, nursing home and home health care policies; loss ratios; continuation and conversion, reserves. (1) FINDINGS. (a) The commissioner finds that long-term care policies and life insurance-long-term care coverage are offered and marketed to a population which is particularly susceptible to pressure sales tactics and misleading or fraudulent sales activities. These products are also complex and difficult for most purchasers to analyze and understand.

(b) The purchase of any of these products is an important and significant decision because of the cost and the significance of these insurance products in planning and providing for long-term care. This section and s. Ins 3.46 are adopted to provide adequate protection for Wisconsin insureds and the public.

(2) APPLICABILITY. (a) This section does not apply to an accelerated benefit coverage of a life insurance policy, endorsement or rider as described under s. Ins. 3.46 (2).

(b) This section, except for subs. (6) and (8), does not apply to individual long-term care policy or life insurance-long-term care coverage, to a group long-term care policy or life insurance-long-term care coverage or a certificate under the group policy, or to a renewal policy or coverage or certificate, if:

1. The individual long-term care policy or life insurance-long-term care coverage was issued prior to June 1, 1991;

2. The group policy is issued prior to June 1, 1991 and all certificates under the policy are issued prior to June 1, 1991; or

3. The group policy is issued prior to June 1, 1991 and the policy is exempt from s. Ins. 3.46 under s. Ins. 3.46 (2) (a).

(c) Section Ins 3.46 in effect prior to June 1, 1991 and subs. (6) and (8) apply to those policies, coverages or certificates which qualify for exemption under par. (b).

(3) DEFINITIONS. In this section:

(a) "Life insurance-long-term care coverage" has the meaning provided under s. Ins 3.46 (3) (d).

(b) "Long-term care policy" has the meaning provided under s. Ins 3.46 (3) (e).

(4) APPLICATION OF THE INSURANCE CODE TO LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE GROUP POLICIES. A group or blanket long-term care policy or certificate may be exempt, under s. 600.01 (1) (b) 3, Stats., from chs. 600 to 646, Stats., and rules adopted under those statutes only if:

(a) The policy is issued for delivery and delivered in another state;

(b) The policy is subject to regulatory requirements substantially similar to those provided under chs. 600 to 646, Stats., and the rules;

(c) The policy is otherwise exempt under s. 600.01 (b) 3, Stats.;

(d) The policy and sufficient information to enable the office to determine compliance with pars. (a) to (c) is filed with the office; and

(e) The office makes a written determination that the policy complies with pars. (a) to (c) and that the policy is not contrary to the public interest, before the policy or certificates under the policy are marketed or solicited in this state.

(5) MINIMUM LOSS RATIO REQUIREMENTS FOR LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES. (a) Insurers shall set and maintain rates and benefits for long-term care policies so that the loss ratio is at least:

1. 65%, for individual policies.

2. 65%, for group policies which issue coverage as the result of solicitation of individuals through the mail or the mass media, including, but not limited to, print or broadcast advertising.

3. 75%, for group policies other than those subject to subd. 2.

(b) For the purpose of this subsection a loss ratio shall be calculated on the basis of the ratio of the present value of the expected benefits to the present value of the expected premium over the entire period of coverage. An insurer shall consider and evaluate the following:

1. Statistical credibility of incurred claims experience and earned premium over the entire period of coverage;

2. The entire period for which rates have been computed to provide coverage;

3. Experienced and projected trends;

4. Concentration of experience within early policy duration;

5. Expected claim fluctuation;

6. Experience refunds, adjustments or dividends;

7. Renewability features;

8. Interest; and

9. Product features such as elimination periods, deductibles and maximum limits.

(c) An insurer shall submit its calculations of the loss ratio for a long-term care policy at the same time it submits a long-term care policy form and at any time that it makes a filing for rates under a long-term care policy.

(6) ANNUAL LOSS RATIO REPORT. An insurer shall annually, not later than April 1, file a report with the office in the form prescribed by the commissioner regarding its loss ratios and loss experience under long-term care policies. The report shall be certified to by a qualified actuary.

(7) LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES, CONTINUATION AND CONVERSION REQUIREMENTS. (a) A group policy, as defined by s. 632.897 (1) (c), Stats., which is a long-term care policy shall provide terminated insureds the right to continue under the group policy as required under s. 632.897, Stats.

(b) An individual long-term care policy which provides coverage for a spouse shall permit the spouse to obtain individual coverage as required under s. 632.897 (9), Stats. upon divorce or annulment.

(c) For the purpose of s. 632.897, Stats., an insurer provides reasonably similar individual coverage to a person converting from a long-term care policy only if the insurer offers an individual policy which is identical to the terminated coverage.

(d) In addition to offering the individual conversion policy as required under par. (c), an insurer may also offer the person the alternative of an individual conversion policy which:

1. Is not underwritten;

2. Complies with this section and s. Ins 3.46;

3. Provides coverage of care in an institutional setting, if the original policy provided coverage in an institutional setting; and

4. Provides coverage of care in a community-based setting, if the original policy provided coverage in a community-based setting.

(8) RESERVE STANDARDS FOR LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES AND LIFE INSURANCE-LONG-TERM CARE COVERAGE. (a) 1. Policy reserves for life insurance-long-term care coverage shall be determined in accordance with s. 623.06 (2) (g), Stats. Claim reserves must also be established if a life insurance-long-term care coverage is in claim status.

2. Reserves for coverage subject to this paragraph should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are

acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefits.

3. In the development and calculation of reserves for policies and riders subject to this subsection , due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

a. Definition of insured events,

b. Covered long-term care facilities,

c. Existence of home convalescence care coverage,

d. Definition of facilities,

e. Existence or absence of barriers to eligibility,

f. Premium waiver provision,

g. Renewability,

h. Ability to raise premiums,

i. Marketing method,

j. Underwriting procedures,

k. Claims adjustment procedures,

l. Waiting period,

m. Maximum benefit,

n. Availability of eligible facilities,

o. Margins in claim costs,

p. Optional nature of benefit,

q. Delay in eligibility for benefit,

r. Inflation protection provisions, and

s. Guaranteed insurability option.

4. Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American academy of actuaries.

(b) Reserves for long-term care policies shall be determined in accordance with s. Ins 3.17 (8) (b) using tables established for reserve purposes by a qualified actuary meeting the requirements of s. Ins 6.12 and acceptable to the commissioner.

History: Cr. Register, April, 1991, No. 424, eff. 6-1-91.

Ins 3.46 Standards for long-term care, nursing home and home health care insurance and life insurance-long-term care coverage. (1) FINDINGS. The findings under s. Ins 3.455 (1) are incorporated by reference. The commissioner finds that the adoption of minimum standards, compensation restrictions and disclosure requirements for long-term care and life insurance-long-term care coverage will reduce marketing abuses and will assist consumers in their attempts to understand the benefits offered and to compare different products. The commissioner finds that failure to comply with this section is misleading and deceptive under s. 628.34 (12), Stats., and constitutes an unfair trade practice.

(2) APPLICABILITY. (a) This section does not apply to a group policy which is issued to one or more employers or labor organizations or to the trustees of a fund established by one or more employers, or labor organizations, or both, for employes or former employes, or both, or for members or former members, or both, of the labor organizations.

(b) This section, except for sub. (10) (b) to (e), does not apply to an individual long-term care policy or life insurance-long-term care coverage, to a group long-term care policy or life insurance-long-term care coverage or a certificate under the group policy, or to a renewal policy or coverage or certificate, if:

1. The individual long-term care policy or life insurance-long-term care coverage was issued prior to June 1, 1991; or

2. The group policy is issued prior to June 1, 1991 and all certificates under the policy are issued prior to June 1, 1991.

(c) Section Ins. 3.46 in effect prior to June 1, 1991 and sub. (10) (b) to (e) apply to those policies, coverages or certificates which qualify for exemption under par. (b).

(d) This section does not apply to an accelerated benefit coverage of a life insurance policy, rider or endorsement which:

1. Provides payments on the occurrence of a severe illness or injury without regard to the incurral of expenses for services relating to the illness or injury; and

2. Is not sold primarily for the purpose of providing coverage of nursing home or home health care, or both.

(3) DEFINITIONS. In this section:

(a) "Compensation" means remuneration of any kind, including, but not limited to, pecuniary or nonpecuniary remuneration, commissions, bonuses, gifts, prizes, awards, finder's fees, and policy fees.

(b) "Guaranteed renewable for life" means a policy renewal provision which continues the insurance in force unless the premium is not paid on time, which prohibits the insurer from changing any provision of the policy, endorsement or rider while the insurance is in force without the express consent of the insured, and which requires the insurer to renew the policy, endorsement or rider for the life of the insured and to maintain the rates in effect for the policy, endorsement or rider at time of issuance, except the provision may permit the insurer to revise rates but on a class basis only.

(c) "Irreversible dementia" means deterioration or loss of intellectual faculties, reasoning power, memory, and will due to organic brain disease characterized by confusion, disorientation, apathy and stupor of varying degrees which is not capable of being reversed and from which recovery is impossible. "Irreversible dementia" includes, but is not limited to, Alzheimer's.

(d) "Life insurance-long-term care coverage" means coverage which:

1. Provides coverage for convalescent or custodial care or care for a chronic condition or terminal illness; and

2. Is included in a life insurance policy or an endorsement or rider to a life insurance policy.

(e) "Long-term care policy" means a disability insurance policy, or an endorsement or rider to a disability insurance policy, designed or intended primarily to be marketed to provide coverage for care that is convalescent or custodial care or care for a chronic condition or terminal illness. "Long-term care policy" includes, but is not limited to, a nursing home policy, endorsement or rider and a home health care policy, endorsement or rider. The term does not include:

1. A medicare supplement policy or medicare replacement policy or an endorsement or rider to such a policy:

2. A continuing care contract, as defined in s. 647.01 (2), Stats.

3. A rider designed specifically to meet the requirements for coverage of skilled nursing care under s. 632.895, Stats.

4. Life insurance-long-term care coverage.

(f) "Medicare" means the hospital and medical insurance program established by Title XVIII, 42 USC 1395 to 1395ss, as amended.

(g) "Medicare eligible persons" means persons who qualify for medicare.

(h) "Outline of coverage" means a document which gives a brief description of benefits in the format prescribed in Appendix 1 to this section and which complies with sub. (8).

(i) "Guide to long-term care" means the pamphlet prescribed by the commissioner which provides information on long-term care insurance and advice to consumers on the purchase of long-term care insurance.

(4) GENERAL FORM REQUIREMENTS FOR LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES AND LIFE INSURANCE-LONG-TERM CARE COVERAGE. Forms for a long-term care policy, life insurance-long-term care coverage and certificates shall:

(a) Provide coverage for each person insured for convalescent and custodial care and care for chronic conditions and terminal illness.

(b) Establish fixed daily benefit limits only if the highest limit is not less than $30 per day.

(c) Establish a fixed daily benefit limit based on the level of the covered care only if the lowest limit of daily benefits provided for under the policy or coverage is not less than 50% of the highest limit of daily benefits.

(d) Provide for an elimination period only if:

1. It is expressed in a number of days per lifetime or per period of confinement;

2. It is clearly disclosed;

3. Days for which medicare provides coverage are counted for the purpose of determining expiration of the elimination period; and

4. It does not exceed 365 days.

(e) Provide for a lifetime maximum limit only if the limit provides not less than 365 days of coverage. Only days of coverage under the policy, coverage or certificate may be applied against a lifetime maximum limit. Coverage by medicare may not be applied against a lifetime maximum limit.

(f) Clearly disclose that it does not cover duplicate payments by medicare for nursing home care or home health care if it has either exclusion.

(g) Provide coverage regardless of whether care is medically necessary. If the form requires that care be provided according to a plan of care, that benefits are available only based on ability to perform activities of daily living, or that benefits are available or vary according to the level of care, the form shall also provide that, in the absence of fraud and collusion, the attending physician's certification of any of those matters is conclusive.

(h) Not limit or condition coverage or benefits by requiring prior hospitalization or prior receipt of care, or benefits for care, in an institutional setting.

(i) Cover irreversible dementia. Coverage may not be excluded or limited on the basis of irreversible dementia.

(j) Define terms used to describe covered services, including, but not limited to, "skilled nursing care," "intermediate care," "personal care," or "home care" services, if those terms are used, in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

(k) Define terms used to describe providers whose services are covered, including, but not limited to, "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility" and "home care agency," if those terms are used, in relation to the services and facilities required to be available and the licensing or degree status of those providing or supervising the services. A definition may require that a provider be appropriately licensed or certified. A form may not exclude coverage of any type of service normally provided by the defined provider, facility or agency.

(l) Clearly disclose any limitations of the coverage.

(m) Not exclude or limit coverage by type of illness, treatment, medical condition or accident, except it may include exclusions or limits for:

1. Preexisting conditions or diseases;

2. Illness, treatment or medical condition arising out of any one or more of the following:

a. Treatment provided in a government facility, unless coverage is otherwise required by law.

b. Services for which benefits are available under medicare or a governmental program other than medicaid, or under a state or federal worker's compensation, employer's liability, occupational disease or motor vehicle no-fault law.

c. Services provided by a member of the insured's immediate family or for which no charge is normally made in the absence of insurance.

(n) Not exclude or limit any coverage of care provided in a community-based setting, including, but not limited to, coverage of home health care, by:

1. Requiring that care be medically necessary;

2. Requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services before community-based care is covered;

3. Limiting eligible services to services provided by registered nurses or licensed practical nurses;

4. Requiring that the insured have an acute condition before community-based care is covered;

5. Limiting benefits to services provided by medicare certified agencies or providers.

(o) Provide substantial scope of coverage of facilities for any benefits it provides for care in an institutional setting.

(p) Provide substantial scope of coverage of facilities and programs for any benefits it provides for care in a community-based setting.

(q) Contain a description of the benefit appeal procedure and comply with s. 632.84, Stats.

(r) If coverage of care in a community-based setting is included, provide coverage of all types of care provided by state licensed or medicare certified home health care agencies.

(s) If coverage of care in an institutional setting is provided, not condition eligibility for coverage of custodial or intermediate care on the concurrent or prior receipt of intermediate or skilled care.

(5) FORM REQUIREMENTS FOR LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES ONLY. (a) This subsection and ss. Ins 3.13 (2) (h) and 3.39 (9) (a) and ss. 632.76 and 632.897, Stats., do not apply to life insurance-long-term care coverage.

(b) A form for long-term care policy or certificate shall:

1. Comply with the restrictions on preexisting condition provisions under s. 632.76, Stats.

2. Include the unrestricted right to return the policy or certificate within 30 days of the date it is received by the policyholder and comply with s. 632.73 (2m), Stats.

3. If it is a policy or certificate which covers care in both institutional and community-based settings, contain a caption as follows:

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR LONG-TERM CARE INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF NURSING HOME AND HOME HEALTH CARE SERVICES. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. READ YOUR POLICY CAREFULLY.

FOR MORE INFORMATION ON LONG-TERM CARE SEE THE "GUIDE TO LONG-TERM CARE" GIVEN TO YOU WHEN YOU APPLIED FOR THIS POLICY. THIS POLICY'S BENEFITS ARE NOT RELATED TO MEDICARE.

4. If it is a policy or certificate which covers care only in an institutional setting, contain a caption as follows:

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR NURSING HOME INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF NURSING HOME CARE. THIS POLICY DOES NOT COVER HOME HEALTH CARE. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. READ YOUR POLICY CAREFULLY.

FOR MORE INFORMATION ON LONG-TERM CARE SEE THE "GUIDE TO LONG-TERM CARE" GIVEN TO YOU WHEN YOU APPLIED FOR THIS POLICY. THIS POLICY'S BENEFITS ARE NOT RELATED TO MEDICARE.

5. If it is a policy or certificate which covers care in a community setting only, contain a caption as follows:

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR HOME HEALTH CARE INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF HOME HEALTH CARE. THIS POLICY DOES NOT COVER NURSING HOME CARE. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. THIS OUTLINE OF COVERAGE PROVIDES A BRIEF DESCRIPTION OF BENEFITS. READ YOUR POLICY CAREFULLY.

FOR MORE INFORMATION ON LONG-TERM CARE SEE THE "GUIDE TO LONG-TERM CARE" GIVEN TO YOU WHEN YOU APPLIED FOR THIS POLICY. THIS POLICY'S BENEFITS ARE NOT RELATED TO MEDICARE.

6. Contain the caption required under subd. 3, 4 or 5 imprinted on the face of the policy or certificate in type not smaller than 18-point and either in contrasting color from the text or with a distinctly contrasting background which is at least as prominent as contrasting color.

7. Include an extension of benefits provision which provides that if the policy is terminated for any reason, including, but not limited to, failure to pay premium, any benefits provided for care in an institutional setting will continue to be payable for institutionalization if the institutionalization begins when the policy is in force and continues without interruption after termination. This extension of benefits may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy elimination period and all other applicable provisions of the policy.

8. If it is an individual policy, be plainly printed in black or blue ink in a uniform type of a style in general use with not less than 10-point with a lower case unspaced alphabet length not less than 120-point. If it is a group policy, certificates issued under the policy shall be plainly printed in black or blue ink in a uniform type of a style in general use, not less than 10-point with a lower case unspaced alphabet length not less than 120-point.

9. If it is an individual policy, include a provision which provides that the policy is guaranteed renewable for life.

(6) NURSING HOME AND HOME HEALTH CARE COVERAGE FORMS MAY NOT USE THE TERM "LONG-TERM CARE". Only a form for a long-term care policy, life insurance-long-term care coverage or certificate which provides substantial coverage of care in both an institutional setting and in a community-based setting may use the term "long-term care" or a substantially similar term.

(7) MISREPRESENTATIONS PROHIBITED. (a) No insurer or intermediary may use the term "long-term care" or similar terminology in an advertisement or offer of a policy, coverage or certificate unless the policy, coverage or certificate advertised or offered:

1. Covers care in both institutional and community-based settings;

2. Complies with this section; and

3. Is approved as a long-term care policy or certificate covering care in both institutional and community settings and as appropriately using the term "long-term care" by the office.

(b) No insurer may file a form under s. 631.20, Stats., for a long-term care policy, life insurance-long-term care coverage or certificate, unless the form complies with this section.

(8) OUTLINE OF COVERAGE. (a) An outline of coverage for a long-term care policy, life insurance-long-term care coverage or certificate shall:

1. Have captions printed in 18-point bold letters and conspicuously placed;

2. Be printed in an easy to read type and written in easily understood language; and

3. Comply with s. Ins 3.27 (5) (1) and (9) (zh).

(b) No insurer or intermediary may use an outline of coverage to comply with sub. (9) or advertise, market or offer a long-term care policy, life insurance-long-term care coverage or certificate, unless prior to the use,

advertising, marketing or offer the outline of coverage is approved in writing by the office.

(9) DISCLOSURE WHEN SOLICITING. An insurer or intermediary at the time the insurer or intermediary contacts a person to solicit the sale of a long-term care policy, life insurance-long-term care coverage or certificate shall deliver to the person:

(a) A copy of the current edition of the guide to long-term care; and

(b) An outline of coverage.

(10) UNDERWRITING. (a) No insurer may issue a long-term care policy, life insurance-long-term care coverage or a certificate to an applicant 75 years of age or older, unless prior to issuing coverage the insurer obtains one of the following:

1. A copy of a physical examination.

2. An assessment of functional capacity.

3. An attending physician's statement.

4. Copies of medical records.

(b) An insurer selling or issuing long-term care policies or life insurance-long-term care coverage shall maintain a record of all policies, coverage or certificate rescissions or reformations, including voluntary rescissions or reformations, categorized by policies, coverages and certificates within this state and nationwide.

(c) An insurer subject to par. (b) shall file a report with the office regarding rescissions and reformations not later than March 1 each year on the form prescribed by the commissioner.

(d) An insurer shall maintain a record of its claims administration guidelines for processing claims under-long term care policies and life insurance-long-term care coverage and shall provide the record to the office on request.

(e) Sections Ins 3.28 and 3.31 apply to long-term care policies.

(11) SALE OF LONG-TERM CARE AND LIMITED BENEFIT POLICIES; REQUIRED OFFER OF COVERAGE WITH INFLATION PROTECTION. (a) No insurer may advertise, market or offer a long-term care policy or certificate unless the insurer has a form approved under s. 631.20, Stats., for the policy or certificate which adds inflation protection no less favorable than one of the following:

1. Benefit levels and maximum benefit amounts increase annually and are annually compounded at a rate of not less than 5%. The policy or certificate may provide that the individual insured or certificate holder will be permitted to decline a benefit increase and that if any benefit increase is declined future increases will not be available. Declination of a increase must be by express written election at the time the increase is to take effect.

2. Benefit levels and maximum benefit amounts increase annually and are annually compounded at a rate equal to the increase in the consumer price index (urban) for the previous year. The insurer may elect to provide in the form that the individual insured or certificate holder will be

permitted to decline a benefit increase and that if the benefit increase is declined future increases will not be available. Such a provision shall provide that declination of an increase shall be by express written election at the time the increase is to take effect.

3. Coverage of a specified percentage, not less than 80%, of actual or reasonable charges for expenses incurred.

(b) No insurer may file a form for a long-term care policy or certificate under s. 631.20, Stats., unless the application form is filed with the policy or certificate form and the application form contains a clear and conspicuous disclosure of the offer required under par. (c).

(c) No insurer or intermediary may contact any person to solicit the sale of a long-term care policy or certificate unless, at the time of contact, the intermediary or insurer makes a clear and conspicuous offer to the person to provide the long-term care policy or certificate with the benefit levels selected by the person and inflation protection as provided under par. (a).

(d) No insurer or intermediary may accept an application for a long-term care policy or certificate unless it is signed by the applicant and the applicant has indicated acceptance or rejection of the inflation protection on the application.

(e) If a long-term care policy is a group policy the applicant for the purpose of par. (d) is the proposed certificate holder.

(f) No insurer or intermediary may advertise or represent that a long-term care policy includes inflation protection unless the policy includes inflation protection at least as favorable as provided under par. (a) 1, 2 or 3.

(g) This subsection does not require an insurer to accept an application for a long-term care policy or certificate with inflation protection as provided by this subsection if the applicant would be rejected under underwriting criteria for the policy or certificate without the inflation protection.

(12) SALE OF LONG-TERM CARE POLICY OR CERTIFICATE OR LIFE INSURANCE-LONG-TERM CARE COVERAGE WITH LENGTHY ELIMINATION PERIOD. (a) No insurer may advertise, market or offer a long-term care policy or certificate, or life insurance-long-term care coverage with an elimination period exceeding 180 days unless the insurer has a form approved under s. 631.20, Stats., providing the identical coverage, but with an elimination period of 180 days or less.

(b) No insurer may file a form for a long-term care policy or certificate or life insurance-long-term care coverage containing an elimination period in excess of 180 days, unless the application form contains a clear and conspicuous disclosure of the offer required under par. (c).

(c) No insurer or intermediary may contact any person to solicit the sale of a long-term care policy or certificate or life insurance-long-term care coverage with an elimination period in excess of 180 days unless, at the time of the contact, the intermediary or insurer makes a clear and conspicuous offer to the person to provide the policy, certificate or coverage with an elimination period of 180 days or less.

(d) No insurer or intermediary may accept an application for a long-term care policy or certificate, or life insurance-long-term care coverage, unless it is signed by the applicant and has indicated acceptance or rejection of the offer required under par. (c) on the application.

(e) If a policy or coverage is a group policy or coverage, the applicant for the purpose of par. (d) is the proposed certificate holder.

(f) This subsection does not require an insurer to accept an applicant for a policy, certificate or coverage with a 180-day or less elimination period if the applicant would be rejected for the same policy, certificate or coverage with the elimination period in excess of 180 days.

(13) COMMISSION LIMITS FOR LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES. (a) An insurer may provide compensation to an intermediary or other representative, and an intermediary or representative may accept compensation for the sale of a long-term care policy or certificate only if:

1. The first year compensation for the sale does not exceed 400% of the compensation paid in the 2nd year or period for the sale or for servicing the policy or certificate; and

2. The compensation provided in subsequent years is the same as provided in the 2nd year or period and is provided for at least 5 renewal years.

(b) No person may provide compensation to an intermediary, representative or producer, and no intermediary, representative or producer may accept compensation, relating to the replacement of a long-term care policy or certificate which is greater than the renewal compensation provided by the replacing insurer for the replacing policy or certificate. Long-term care policies this paragraph applies to include, but are not limited to, long-term care policies, nursing home policies and home health care policies issued prior to June 1, 1991.

(14) REPLACEMENT; LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES. (a) If a long-term care policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

(b) If a group long-term care policy is replaced by another group long-term care policy purchased by the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(c) Application forms for long-term care policies or certificates shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except

where the coverage is sold without an agent, containing such questions may be used.

1. Do you have another long-term care, nursing home or home health care policy or certificate in force (including a health maintenance organization policy or certificate)?

2. Did you have another long-term care, nursing home or home health care policy or certificate in force during the last 12 months?

a. If so, with which company?

b. If the policy or certificate lapsed, when did it lapse?

3. Are you covered by Medicaid?

4. Do you intend to replace any of your medical or health insurance coverage with this policy or certificate?

(d) An intermediary taking an application for a long-term care policy or certificate shall:

1. List any other health insurance policies or certificates the intermediary has sold to the applicant;

2. List separately the policies or certificates that are still in force;

3. List policies or certificates sold in the past which are no longer in force; and

4. Submit the lists to the insurer with the application.

(e) Section Ins. 3.29 applies to the solicitation and sale of long-term care policies and certificates.

(f) Every insurer and person marketing long-term care insurance coverage in this state, directly or through its producers, shall:

1. Establish marketing procedures to assure that any comparison of policies by its intermediaries or other producers will be fair and accurate.

2. Establish marketing procedures to assure excessive insurance is not sold or issued.

3. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for a long-term care policy or certificate already has accident and sickness or a long-term care policy or certificate and the types and amounts of any such insurance.

4. Establish auditable procedures for verifying compliance with this paragraph.

(g) No person may:

1. Knowingly make any misleading representation or incomplete or fraudulent comparison of any insurance policies, certificates or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy, certificate or to take out a policy of insurance or certificate with another insurer.

2. Employ any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether

explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

3. Make use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(h) In recommending the purchase or replacement of any long-term care policy or certificate an intermediary shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(i) In regards to any transaction involving a long-term care policy or certificate, no person subject to regulation under chs. 600 to 655, Stats., may knowingly prevent or dissuade or attempt to prevent or dissuade, any person from:

1. Filing a complaint with the office of the commissioner of insurance; or

2. Cooperating with the office of the commissioner of insurance in any investigation; or

3. Attending or giving testimony at any proceeding authorized by law.

(j) Replacement of long-term care, nursing home and home health care policies and certificates issued prior to June 1, 1991 is also subject to this subsection.

History: Cr. Register, June, 1981, No. 305, eff. 11-1-81; cr. (3) (c), Register, June, 1982, No. 318, eff. 7-1-82; am. (1) and (3) (b), Register, March, 1985, No. 351, eff. 4-1-85; (6m) deleted under s. 13.93 (2m) (b) 16, Stats., Register, March, 1985, No. 351; r. and recr. Register, December, 1986, No. 372, eff. 1-1-87; r. and recr., Register, April, 1991, No. 424, eff. 6-1-91.

Ins 3.46 Appendix I

(COMPANY NAME)

OUTLINE OF COVERAGE

(Insert the appropriate caption stated below.)

LONG-TERM CARE INSURANCE POLICY

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR LONG-TERM CARE INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF NURSING HOME AND HOME HEALTH CARE SERVICES. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. THIS OUTLINE OF COVERAGE PROVIDES A BRIEF DESCRIPTION OF BENEFITS. READ YOUR POLICY CAREFULLY.

or

NURSING HOME INSURANCE POLICY

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR NURSING HOME INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF NURSING HOME CARE. THIS POLICY DOES NOT COVER HOME HEALTH CARE. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. THIS OUTLINE OF COVERAGE PROVIDES A BRIEF DESCRIPTION OF BENEFITS. READ YOUR POLICY CAREFULLY.

or

HOME HEALTH CARE INSURANCE POLICY

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR HOME HEALTH CARE INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF HOME HEALTH CARE. THIS POLICY DOES NOT COVER NURSING HOME CARE. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. THIS OUTLINE OF COVERAGE PROVIDES A BRIEF DESCRIPTION OF BENEFITS. READ YOUR POLICY CAREFULLY.

plus

FOR MORE INFORMATION ON LONG-TERM CARE SEE THE "GUIDE TO LONG-TERM CARE" GIVEN TO YOU WHEN YOU APPLIED FOR THIS POLICY.

THIS POLICY'S BENEFITS ARE NOT RELATED TO MEDICARE.

(1) The outline of coverage shall contain a description of the following items, if applicable:

(a) Pre-existing condition limitation

(b) Elimination periods

(c) Exclusions and limitations in the policy

(d) Prior authorization procedures

(e) Benefit periods and lifetime maximums in the policy

(f) Renewability provision of the policy

(g) "Free look" provisions of the policy

(h) Inflation protection provisions

(i) Definitions for skilled, intermediate and custodial care, activities of daily living, home health care, and respite care

(j) Benefit appeals internal procedures.

(2) The outline shall contain a statement that the policy will provide benefits for persons with irreversible dementia if the person requires the type of care covered by the policy and is otherwise eligible for benefits.

(3) A summary of the costs of the policy and any optional rider purchased. The summary may be completed at the time the outline is provided to an applicant.

(4) For life insurance products, a statement that the cash value and death benefits will be reduced if claims are paid under life insurance-long-term care coverage.

Ins 3.47 Cancer insurance solicitation. (1) FINDINGS. Information on file in the office of the commissioner of insurance shows that significant misunderstanding exists with respect to cancer insurance. Consumers are not aware of the limitations of cancer insurance and do not know how cancer insurance policies fit in with other health insurance coverage. Many of the sales presentations used in the selling of cancer insurance are confusing, misleading and incomplete and consumers are not getting the information they need to make informed choices. The commissioner of insurance finds that such presentations and sales materials are misleading, deceptive and restrain competition unreasonably as considered by s. 628.34 (12), Stats., and that their continued use without additional information would constitute an unfair trade practice under s. 628.34 (11) and would result in misrepresentation as defined and prohibited in s. 628.34 (1), Stats.

(2) PURPOSE. This section interprets s. 628.34 (12), Stats., relating to unfair trade practices. It requires insurers and intermediaries who sell cancer insurance to give all prospective buyers of cancer insurance a shopper's guide prepared by the national association of insurance commissioners.

(3) SCOPE. This section applies to all individual, group and franchise insurance policies or riders which provide benefits for or are advertised as providing benefits primarily for the treatment of cancer. This section does not apply to solicitations in which the booklet, "Health Insurance Advice for Senior Citizens," is given to applicants as required by s. Ins 3.39.

(4) DEFINITION. "A Shopper's Guide to Cancer Insurance" means the document which contains the language set forth in Appendix I to this section.

(5) DISCLOSURE REQUIREMENTS. (a) Each insurer offering a policy or rider described in sub. (3) shall print, and the insurer and its intermediaries shall provide to all prospective purchasers of any policy or rider subject to this section, a copy of "A Shopper's Guide to Cancer

Next page is numbered 160-1

(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; renum. from Ins 3.51, Register, August, 1990, No. 416, eff. 9-1-90.

Ins 3.53 HIV testing. (1) FINDINGS. The tests listed in sub. (4) (e) 1 to 3 have been specified by the state epidemiologist in part C of a report entitled "Validated positive tests and medically significant and sufficiently reliable tests to detect the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV," dated August 31, 1990. The

commissioner of insurance, therefore, finds that these tests are sufficiently reliable for use in underwriting individual life, accident and health insurance policies.

(2) PURPOSES. The purposes of this section are:

(a) To implement s. 631.90 (3) (a), Stats.

(b) To establish procedures for insurers to use in obtaining informed consent for HIV testing and informing individuals of the results of a positive HIV test.

(c) To ensure the confidentiality of HIV test results.

(d) To restrict the use of certain information on HIV testing in underwriting group life, accident and health insurance policies.

(3) DEFINITIONS. In this section:

(a) "AIDS" means acquired immunodeficiency syndrome.

(b) "AIDS service organization" means a community-based organization in this state that provides AIDS prevention and education services to the general public and offers direct support services to persons with HIV infection at no cost.

(c) "ELISA" means enzyme-linked immunosorbent assay.

(d) "FDA-licensed test" means a test of a single whole blood, serum or plasma specimen which has been approved by the federal food and drug administration.

(e) "Health care provider" has the meaning given under s. 146.81 (1), Stats.

(f) "HIV" has the meaning given under s. 631.90 (1), Stats.

(g) "Medical information bureau, inc." means the nonprofit Delaware incorporated trade association, the members of which are life insurance companies, that operates an information exchange on behalf of its members.

(h) "State epidemiologist" has the meaning given under s. 146.025 (1) (f), Stats.

(i) "Wisconsin AIDSline" means the statewide AIDS information and medical referral service.

(4) TESTING; USE; PROHIBITIONS. (a) For use in underwriting an individual life, accident or health insurance policy, an insurer may require that the person to be insured be tested, at the insurer's expense, for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV.

(b) An insurer that requires a test under par. (a) shall, prior to testing, obtain a signed consent form, in substantially the format specified in Appendix A, either from the person to be tested or from one of the following if the specified condition exists:

1. The person's parent or guardian, if the person is under 14 years of age.

2. The person's guardian, if the person is adjudged incompetent under ch. 880, Stats.

3. The person's health care agent, as defined in s. 155.01 (4), Stats., if the person has been found to be incapacitated under s. 155.05 (2), Stats.

(c) The insurer shall provide a copy of the consent form to the person who signed it and shall maintain a copy of each consent form for at least one year.

(d) The insurer shall provide with the consent form a copy of the document, "Resources for persons with a positive HIV test/The implications of testing positive for HIV." Each insurer shall either obtain copies of the document from the office of the commissioner of insurance or reproduce the document itself. If the document is revised, the insurer shall begin using the revised version no later than 30 days after receiving notice of the revision from the office of the commissioner of insurance.

Note: The document referred to in this paragraph is form number OCI 26-002. It may be obtained from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, Wisconsin 53707-7873.

(e) The only tests an insurer may use under par. (a) are the following:

1. An FDA-licensed test that is positive for the presence of an HIV antigen.

2. An FDA-licensed ELISA test that is reactive for the presence of an antibody to HIV at least twice, followed by a reactive western blot test.

3. An FDA-licensed latex agglutination test that is positive for the presence of an antibody to HIV at least once, followed by a reactive western blot test.

(f) For purposes of par. (e) 2 and 3, a western blot test is reactive when any 2 of the following protein or glycoprotein bands are present:

1. p24.

2. gp41.

3. gp120 or gp160.

Note: Because of the difficulty of distinguishing the gp120 band from the gp160 band, the state epidemiologist has determined that the 2 glycoprotein bands may be considered as one reactant for the purpose of interpreting a western blot test.

(g) A test under par. (e) shall be performed by a laboratory that participates in and satisfies the standards of a generally recognized HIV proficiency testing program, including a program conducted by the federal centers for disease control, the American association of bioanalysts, the college of American pathologists or a similar program with specifications that meet the standards of those programs.

Note: An insurer may use any of the tests described in pars. (e) to (g), in underwriting individual life, accident and health insurance applications on and after May 1, 1991.

(h) 1. An insurer that uses an application asking whether the person to be insured has been tested for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV may ask only whether the person has been tested using one or more of the tests specified in par. (e).

2. Notwithstanding subd. 1, the insurer may not require or request the disclosure of any information as to whether the person to be insured has been tested at an anonymous counseling and testing site designated by the state epidemiologist or at a similar facility in another jurisdiction, or to reveal the results of such a test.

(5) POSITIVE TEST RESULT; INSURER'S OBLIGATION. (a) If a test under sub. (4) (e) is positive and, in the normal course of underwriting, affects the issuance or terms of the policy, the insurer shall provide written notice to the person who signed the consent form that the person tested does not meet the insurer's usual underwriting criteria because of a test result. The insurer shall request that the person provide informed consent for disclosure of the test result to a health care provider with whom the person wants to discuss the test result.

(b) If informed consent for disclosure is obtained, the insurer shall provide the designated health care provider with the test result. If the person refuses to give informed consent for disclosure, the insurer shall, upon the person's request, provide the person who signed the consent form with the test result. The insurer shall include with the report of the test result all of the following:

1. A statement that the person should contact a private health care provider, a public health clinic, an AIDS service organization or the Wisconsin AIDSline for information on the medical implications of a positive test, the desirability of further independent testing and the availability of anonymous testing.

2. The toll-free telephone number of the Wisconsin AIDSline.

3. Copies of the document specified in sub. (4) (d).

(6) CONFIDENTIALITY OF TEST RESULTS. An insurer that requires a person to be tested under sub. (4) (a) may disclose the test result only as described in the consent form obtained under sub. (4) (b) or with written consent for disclosure signed by the person tested or a person specified in sub. (4) (b) 1 to 3.

Note: Subsections (4) (a) to (d), (5) and (6) first apply to applications taken on November 1, 1991.

(7) GROUP POLICIES; ADDITIONAL PROHIBITION. In underwriting group life, accident or health insurance on an individual basis, in addition to the restrictions specified in s. 631.90 (2), Stats., an insurer may not use or obtain from any source, including the medical information bureau, inc., any of the following:

(a) The results of a person's test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV.

(b) Any other information on whether the person has been tested for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV.

Note: Subsections (6) (a), (b) and (e) and (7), as they exist on April 30, 1991, continue to apply to informed consent for testing and disclosure of test results until November 1, 1991.

History: Cr. Register, May, 1987, No. 377, eff. 6-1-87; r. and recr. Register, April, 1991, No. 424, eff. 5-1-91.

Ins 3.53
APPENDIX A

[Insurer name and address]

WISCONSIN NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TEST

REQUEST FOR CONSENT FOR TESTING

To evaluate your insurability, _____(insurer name)_____ (Insurer) requests that you provide a sample of your blood for testing and analysis, to determine the presence of human immunodeficiency virus (HIV) antibody or antigens. By signing and dating this form, you agree that this test may be done and that underwriting decisions may be based on the test results. A licensed laboratory will perform one or more tests approved by the Wisconsin Commissioner of Insurance.

PRETESTING CONSIDERATION

Many public health organizations recommend that, if you have any reason to believe you may have been exposed to HIV, you become informed about the implications of the test before being tested. You may obtain information about HIV and counseling from a private health care provider, a public health clinic, or one of the AIDS service organizations on the attached list. You may also wish to obtain an HIV test from an anonymous HIV counseling and testing site before signing this consent form. The Insurer is prohibited from asking you whether you have been tested at an anonymous HIV counseling and testing site and from obtaining the results of such a test. **For further information on these options, contact the Wisconsin AIDSline at 1-800-334-2437.**

MEANING OF POSITIVE TEST RESULTS

Any test administered is not a test for AIDS. It is a test for antibodies to or antigens of HIV, the causative agent for AIDS, and shows whether you have been infected by the virus. A positive test result may have an effect on your ability to obtain insurance. A positive test result does not mean that you have AIDS, but it does mean that you are at a seriously increased risk of developing problems with your immune system. HIV tests are very sensitive and specific. Errors are rare but they can occur. If your test result is positive, you may wish to consider further independent testing from your physician, a public health clinic, or an anonymous HIV counseling and testing site. **HIV testing may be arranged by calling the Wisconsin AIDSline at 1-800-334-2437.**

NOTIFICATION OF TEST RESULTS

If your HIV test result is negative, no routine notification will be sent to you. If your HIV test result is other than normal, the Insurer will contact you and ask for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the test results.

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The laboratory that does the testing will report the result to the Insurer. If necessary to process your application, the Insurer may disclose your test result to another

entity such as a contractor, affiliate, or reinsurer. If your HIV test is positive, the Insurer may report it to the Medical Information Bureau (MIB, Inc.), as described in the notice given to you at the time of application. If your HIV test is negative, no report about it will be made to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. These organizations may not disclose the fact that the test has been done or the result of the test except as permitted by law or authorized in writing by you.

CONSENT

I have read and I understand this notice and consent for AIDS-related blood testing. I voluntarily consent to the withdrawal of my blood, the testing of that blood, and the disclosure of the test result as described above. A photocopy or facsimile of this form will be as valid as the original.

_____

Signature of Proposed Insured or Parent, Guardian, or Health Care Agent/Date

_____

Name of Proposed Insured (Print)

_____

Date of Birth

_____

Address

_____

City, State, and Zip Code

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 appropriately 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.

Ins 3.55 Benefit appeals under long-term care policies, life insurance-long-term care coverage and medicare replacement or supplement policies. (1) PURPOSE. This section implements and interprets s. 632.84, Stats., for the purpose of establishing minimum requirements for the internal procedure for benefit appeals that insurers shall provide in long-term care policies, life insurance-long-term care coverage and medicare replacement or supplement policies. This section also facilitates the review by the commissioner of these policy forms.

(2) SCOPE. This section applies to individual and group nursing home insurance policies and medicare replacement or supplement policies issued or renewed on or after August 1, 1988, and to long-term care policies and life insurance-long-term care coverage issued or renewed on and after June 1, 1991, except for policies or coverage exempt under s. Ins 3.455 (2) (b). This section does not apply to a health maintenance organization, limited service health organization or preferred provider plan, as those are defined in s. 609.01, Stats.

(3) DEFINITIONS. In this section:

(a) "Benefit appeal" means a request for further consideration of actions involving the denial of a benefit.

(b) "Denial of a benefit" means any denial of a claim, the application of a limitation or exclusion provision, and any refusal to continue coverage.

(c) "Internal procedure" means the insurer's written procedure for handling benefit appeals.

(cg) "Life insurance-long-term care coverage" has the meaning provided under s. Ins. 3.46 (3) (d).

(cm) "Long-term care policy" has the meaning provided under s. Ins 3.46 (3) (e).

(d) "Medicare replacement policy" has the meaning given in s. 600.03 (28p), Stats.

(e) "Medicare supplement policy" has the meaning given in s. 600.03 (28r), Stats.

(4) MINIMUM REQUIREMENTS. (a) Pursuant to s. 632.84 (2), Stats., an insurer shall include in any long-term care policy, life insurance-long-term care coverage and any medicare replacement or supplement policy an internal procedure for benefit appeals.

(b) The insurer shall provide the policyholder and insured with a written description of the benefit appeals internal procedure at the time the insurer gives notice of the denial of a benefit. The written description shall include the name, address, and phone number of the individual designated by the insurer to be responsible for administering the benefit appeals internal procedure.

(c) An insurer shall describe the benefit appeals internal procedure in every policy, group certificate, and outline of coverage. The description shall include a statement on the following:

1. The insured's right to submit a written request in any form, including supporting material, for review by the insurer of the denial of a benefit under the policy; and

2. The insured's right to receive notification of the disposition of the review within 30 days of the insurer's receipt of the benefit appeal.

(d) An insurer shall retain records pertaining to a benefit appeal filed and the disposition of this appeal for at least 3 years from the date that the insurer files with the commissioner under sub. (5) the annual report in which information concerniing the appeal is reported.

(e) No insurer may impose a time limit for filing a benefit appeal that is less than 3 years from the date the insurer gives notice of the denial of a benefit.

(f) An insurer shall make any internal procedure established pursuant to s. 632.84, Stats., available to the commissioner upon request and in as much detail as the commissioner requests.

(5) REPORTS TO THE COMMISSIONER. An insurer shall report to the commissioner by March 31 of each year a summary of all benefit appeals filed during the previous calendar year and the disposition of these appeals, including:

(a) The name of the individual designated by the insurer to be responsible for administering the benefit appeals internal procedure;

(b) Changes made in the administration of claims as a result of the review of benefit appeals;

(c) For each benefit appeal, the line of coverage;

(d) The date each benefit appeal was filed and, if within the calendar year, subsequently resolved;

(e) The date each benefit appeal carried over from the previous calendar year was resolved;

(f) The nature of each benefit appeal; and

(g) A summary of each benefit appeal resolution.

(6) POLICY DISAPPROVAL. The commissioner shall disapprove a policy under s. 631.20, Stats., if that policy does not meet the minimum requirements specified in this section.

History: Cr. Register, May, 1989, No. 401, eff. 1-1-90; am. (1), (2) and (4) (a), r. (3) (f), cr. (3) (cg) and (cm), Register, April, 1991, No. 424, eff. 6-1-91.

APPENDIX 1

(COMPANY NAME)
OUTLINE OF MEDICARE SUPPLEMENT INSURANCE
or
OUTLINE OF MEDICARE REPLACEMENT INSURANCE
(The designation and caption required by sub. (4) (b) 4.)

(1) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. READ YOUR POLICY CAREFULLY!

(2) (a) The outline of coverage for a medicare supplement insurance policy shall contain the following language:

Medicare Supplement Insurance Policy: This policy supplements Medicare. It covers some hospital, skilled nursing facility, medical, surgical, and other outpatient services which are partially covered by Medicare. It will not cover all your health care expenses. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.

(b) The outline of coverage for a medicare replacement insurance policy shall contain the following language:

Medicare Replacement Insurance Policy: This policy provides basic Medicare hospital and physician benefits. It also includes benefits beyond those provided by Medicare. This policy is a replacement for Medicare and is subject to certain limitations in choice of providers and area of service. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.

(3) (a) In 24-point type: For medicare supplement policies marketed by intermediaries:

Neither (Insert company's name) nor its agents are connected with Medicare.

(b) In 24-point type: For medicare supplement policies marketed by direct response:

(Insert company's name) is not connected with Medicare.

(c) For medicare replacement policies:

(Insert company's name) has contracted with Medicare to provide Medicare benefits. Except for emergency care anywhere or urgently needed care when you are temporarily out of the service area, all services, including all Medicare services, must be provided or authorized by (insert company's name).

(4) (a) For medicare supplement policies, provide a brief summary of the major benefits and gaps in Medicare Parts A & B with a parallel description of supplemental benefits, including dollar amounts, as outlined in these charts.

(b) For medicare replacement policies, provide a brief summary of both the basic Medicare benefits in the policy and additional benefits using the basic format as outlined in these charts and modified to accurately reflect the benefits.

(c) If the coverage is provided by a health maintenance organization as defined in s. 609.01 (2), Stats., provide a brief summary of the coverage for emergency care anywhere and urgent care received outside the service area if this care is treated differently than other covered benefits.