

Navigator Study Guide

**State of Wisconsin
Office of the Commissioner of Insurance
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Introduction

This guide is written for individuals who are preparing for the navigator examination. It is a brief summary of select laws and rules and is not a complete summary.

It is suggested that navigators obtain a complete copy of the Wisconsin Administrative Code and the Statutes from our Web site (oci.wi.gov) or from the Department of Administration, Document Sales and Distribution, 202 South Thornton Avenue, Madison, WI 53702, telephone (608) 266-3358. The Wisconsin Insurance Laws are also available from NILS Publishing Company, 20675 Bahama Street, P. O. Box 2507, Chatsworth, CA 91311. Information on the federal law and regulations is available on the Regulations and Guidance section of the Web site for The Center for Consumer Information & Insurance Oversight (www.cms.gov/ccio).

Applicants for a navigator license and certified application counselors have to take a prelicensing training course and pass a written examination in addition to any exchange-related training mandated by the federal government.

Each person taking an examination will be responsible for knowing the material covered in this guide. The guide should be read carefully and completely. An effort has been made to simplify complex statutory language.

If an answer or example seems confusing, misleading, or incorrect, readers should consult the applicable statute or insurance rule. Most answers include numbers in brackets “[]” to a specific state statute and/or administrative rule.

A statute is a state law passed by the Wisconsin Legislature. In this guide, statutory references have an “s.” or a “ch.” before them, as in “s. 628.34” or “ch. 628.” This refers the reader to a particular section or chapter of the Wisconsin Statutes (Wis. Stat.). An insurance rule implements the general requirements of the law. In this guide, an insurance rule has an “s. Ins” before it, as in “s. Ins 3.27,” which refers the reader to s. Ins 3.27 of the Wisconsin Administrative Code (Wis. Adm. Code). The Commissioner promulgates insurance rules under authority delegated to the Commissioner by the Wisconsin Legislature.

The Office of the Commissioner of Insurance (OCI) will update the guide periodically but readers should not rely solely on the material in this guide to stay informed of statute and rule changes. This guide is not intended to be a complete summary of the statutes and rules about which navigators should be aware. Navigators should also pay particular attention to the Wisconsin Insurance News, the quarterly newsletter available on the OCI Web site (oci.wi.gov). OCI also maintains several electronic mailing lists used to announce the issuance of bulletins to insurers, press releases, and/or the availability of the latest edition of the Wisconsin Insurance News. Readers may subscribe to one or more of OCI's electronic mailing lists online at oci.wi.gov/listserv.htm.

I. Affordable Care Act

A. Intent of the Law

The federal Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148), signed March 23, 2010, as amended by the Health Care and Education Reconciliation Act, signed March 31, 2010, is also referred to as the Affordable Care Act (ACA), or simply as “federal health reform.”

B. Major Provisions

The 900 plus page act contains many provisions, with various effective dates. Key provisions are intended to expand access to health insurance, increase consumer protections, emphasize prevention and wellness, improve health care quality and system performance, expand the health care workforce and curb rising health care costs.

On June 28, 2012, in a 5-4 decision, the United States Supreme Court declared constitutional PPACA's individual mandate, which requires virtually all U.S. citizens to obtain health insurance coverage or pay a penalty (*NFIB v Sibelius*, U.S., No. 11-393, 6/28/12).

In the other major holding, the Court declared the Medicaid provision constitutional, but only if the threat to the states for noncompliance is limited to loss of new funds provided under PPACA. States that choose to comply with the Medicaid expansion would receive regular Medicaid funding as well as the additional funding under PPACA. States that did not select Medicaid expansion would not get the additional funds. Wisconsin has chosen not take the Medicaid expansion.

C. Market Wide Reforms

Some provisions of the Affordable Care Act were effective in 2010:

- No lifetime limits
- Limitations on annual limits for essential benefits
- Federal standards for internal and external review
- No preexisting condition limitations for children under 19
- Dependents are eligible for coverage to age 26
- Preventive services covered without cost sharing
- Rescissions prohibited
- Temporary high-risk pool
- Federal rate review standards
- Medical loss ratio standards and rebates if ratios are not met
- Uniform summary of benefits and coverage

Market wide reforms are effective for policies issued on or after January 1, 2014. Health insurance exchanges are created for the individual and small group health insurance markets. The health insurance market outside of the exchanges continues to function.

Some provisions apply to the entire market, both inside and outside the exchange:

- All plans must meet certain levels of coverage.

Bronze level—The plan must cover 60% of expected costs across a standard population. This is the lowest level of coverage.

Silver level—The plan must cover 70% of expected costs across a standard population.

Gold level—The plan must cover 80% of expected costs across a standard population.

Platinum level—The plan must cover 90% of expected costs across a standard population. This is the highest level of coverage.

A catastrophic plan will be offered and will cover the same services. But its coverage will be slightly less generous than the bronze level plans. A catastrophic plan may be a less expensive option for those who are eligible; only young adults under 30 and individuals who have a hardship exemption from the individual mandate are allowed to purchase catastrophic plans.

- The metal levels are defined using the concept of “actuarial value.” Actuarial value measures the percentage of total overall health care costs for the essential health benefits covered by a plan. This is the average share of medical spending that the plan pays, measured across a standard population. The percentage of total average costs the plan pays depends on the cost-sharing details—how much out-of-pocket the consumer pays for deductibles, coinsurance, and copayments and the out-of-pocket limits. A silver plan with a value of 70% means that, for a standard population, the plan will pay 70% of health care expenses through some combination of deductibles, copayments and coinsurance.
- All plans must cover essential health benefits.
- Single risk pool for individual and small group.
- Limited rating rules: only age, tobacco use, geography and family size.
- Plans are available only during the annual open enrollment period, except for special circumstances.

Plans offered on the exchange must meet additional requirements. An insurer must offer at least one gold and one silver plan and charge the same price inside and outside of the exchange. The plans must meet marketing requirements, network adequacy requirements, include access to essential community providers, be accredited, implement quality improvement strategies and use the uniform enrollment forms.

The Affordable Care Act requires health plans to cover essential health benefits (EHB). Essential health benefits include items and services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

The essential health benefits should be equal in scope to a typical employer health plan. Most health insurance plans already cover the essential benefits with the exception of habilitative services and wellness services.

Habilitative services are services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age.

Essential health benefits are defined by a benchmark plan in each state. Federal regulations set out standards for selecting the benchmark plan. The default plan is the largest product in the state's small group health insurance market by enrollment. All benefits in the Wisconsin benchmark plan are essential

health benefits in this state and all plans in the individual and small group markets must offer, at a minimum, benefits that are substantially equal to the essential health benefits benchmark plan. There are standards for determining if the benefits are substantially equal. More information on the benchmark plan is available on the OCI Federal Health Care Reform Web site. The federal government plans to assess the benchmark process for the year 2016.

D. Tax Penalties and Shared Responsibility (ISRP)

Individuals are required to have minimum essential coverage. Individuals must maintain minimum essential coverage or pay a tax penalty. Minimum essential coverage includes Medicare, Medicaid, and comprehensive health plans at least at the bronze level of coverage. It does not include limited benefit plans.

Employer plans must provide minimum value and premium must be affordable for employees or the employer will pay penalties. Coverage is not affordable if the cost of employee-only coverage under the employer plan costs the consumer more than 9.5% of the employee's annual household income. The plan does not provide minimum value if it pays for less than 60% of medical costs that the plan covers. The federal government has developed a minimum value calculator at www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm.

An employer can provide a consumer with a minimum value written statement stating whether the plan is above or below the 60% threshold. More information is available on the IRS Web site at www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions.

If an individual does not have minimum essential coverage, he or she will pay a penalty when the tax return is filed. The penalty in 2014 is either \$95 or 1% of yearly household income, whichever is higher. More detailed information is available on the IRS Web site.

Individuals meeting certain circumstances may be exempt from the federal tax or individual shared responsibility payment. Individuals may qualify for an exemption if:

- They are uninsured for less than 3 months of the year.
- The lowest-priced coverage available would cost more than 8% of household income.
- The individual does not have to file a tax return because the income is too low.
- The individual is a member of a federally recognized tribe or eligible for services through an Indian Health Services provider.
- The individual is a member of a recognized health care sharing ministry.
- The individual is a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare.
- The individual is incarcerated (either detained or jailed) and not being held pending disposition of charges.
- The individual is not lawfully present in the U.S.

Further information on how to claim these exemptions is available on the healthcare.gov Web site.

There are also hardship exemptions. Individuals file forms to request the exemptions. The circumstances below may qualify for a “hardship” exemption:

- You were homeless.
- You were evicted in the past 6 months or were facing eviction or foreclosure.
- You received a shut-off notice from a utility company.
- You recently experienced domestic violence.
- You recently experienced the death of a close family member.
- You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property.
- You filed for bankruptcy in the last 6 months.
- You had medical expenses you couldn't pay in the last 24 months which resulted in substantial debt.
- You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.
- You expect to claim a child as a tax dependent who has been denied coverage in Medicaid and another person is required by court order to give medical support to the child. In this case, you do not have to pay the penalty for the child.
- As a result of an eligibility appeals decision, you are eligible for enrollment in a qualified health plan (QHP) through the Marketplace, lower costs on your monthly premiums, or cost-sharing reductions for a time period when you were not enrolled in a QHP through the Marketplace.
- You were determined ineligible for Medicaid because your state did not expand eligibility for Medicaid under the Affordable Care Act.
- Your individual insurance plan was cancelled and you believe other Marketplace plans are unaffordable.
- You experienced another hardship in obtaining health insurance.

Further information about filing an application for a hardship exemption is available on the healthcare.gov Web site <https://www.healthcare.gov/exemptions/>.

E. Tribal Considerations

There are special provisions for American Indians and Alaska natives purchasing coverage through the health insurance exchange. These include eliminating cost sharing for Indians with household incomes under 300% of the federal poverty level who are enrolled in a qualified health plan through an individual market exchange; elimination of cost sharing for Indians enrolled in a qualified health plan through an individual market exchange, regardless of income, when services are provided by the Indian Health Service or related providers; exemption from the individual shared responsibility provisions and special monthly enrollment periods.

II. Basic Health Insurance Concepts

A. Types of Comprehensive Health Plans

1. Health maintenance organization plans are plans that may require selection of a primary care provider and require that consumers see plan providers for care.
2. Preferred provider organization plans provide an incentive to use providers who have a contract with the plan but will provide coverage with increased cost sharing for non-plan providers.
3. Point-of-service plans are usually offered by health maintenance organization plans and permit the use of non-plan providers with increased cost sharing.
4. High-deductible health plans provide coverage after the deductible is satisfied.
5. Health savings accounts and health reimbursement accounts are pretax accounts established under Internal Revenue Service guidelines. A health savings account (HSA) is a tax-advantaged medical savings account available to taxpayers who are enrolled in a high-deductible health plan. The individual owns his or her own HSA and contributions can be made by the individual or an employer.
6. Health reimbursement arrangements (HRA) are funded by employers and are an alternate tax-deductible source of funds paired with either high-deductible health plans or standard health plans. The funds contributed to an account are not subject to federal income tax at the time of deposit.

B. Excepted Benefits

Limited benefit hospital medical surgical policies provide fixed dollar amounts such as \$100 a day in the hospital or \$200 for a surgical procedure. These policies are sold as supplemental to comprehensive health plans and do not meet the definition of minimum essential benefits.

Short-term plans are health plans issued for a limited period of time not to exceed 12 months.

Dental and vision only plans provide coverage for dental or vision services only.

C. Insurance Terms

1. A copayment is a fixed amount (for example, \$15) a person pays for a covered health care service, usually when the person receives the service. The amount can vary by the type of covered health care service.
2. A deductible is the amount a person owes for health care services the health insurance plan covers before the health insurance begins to pay. For example, if the deductible is \$1,000, the plan will not pay anything until the person meets the \$1,000 deductible for covered health care services that are subject to the deductible.
3. Coinsurance is the share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. The person pays coinsurance plus any deductibles. For example, if the health insurance plan's allowed amount for an office visit is \$100 and the person has met the plan deductible, the coinsurance payment of 20% would be \$20. The health insurance plan pays 80% of the allowed amount.

III. Health Insurance Exchanges

A. Types of Exchanges

States had the option to create health insurance exchanges or to defer to the federal government. States deferring to the federal government had the option to enter into a partnership regarding some plan management functions. Wisconsin uses the federally facilitated exchange managed by the federal government.

B. Individual Exchange

The individual exchange allows individuals shopping for coverage one place to go to consider coverage choices, determine eligibility for public programs or tax credits, use tools to compare plans and receive help through the Web site, call center or from navigators trained to assist individuals. The exchange offers qualified health plans, provides information on premiums, deductibles, out-of-pocket costs, and tools to compare plans.

Consumers must purchase coverage through the individual exchange if they wish to receive the tax credits. Advance payments of the tax credit can be used to lower monthly premium costs. If the consumer qualifies, he or she may decide how much advance credit to apply to the premium each month, up to a maximum amount. If the amount of the advance credit is less than the tax credit due, the consumer will get the difference as a refundable credit on the federal tax return. If the advance payments for the year are more than the amount of the tax credit, the consumer must repay the excess advance payments with the tax return.

C. Small Business Health Options Program Exchange

The Small Business Health Options Program (SHOP) exchange provides small employers with 2 to 50 employees one place to go to sign up for coverage among insurers that are part of the SHOP exchange.

Small businesses with fewer than 25 full-time employees with wages less than \$50,000 a year may be eligible for a tax credit if the employer pays at least half of the employee's premium and the employer purchases coverage through the SHOP exchange. There is a SHOP tax credit estimator on the healthcare.gov Web site at <https://www.healthcare.gov/small-business-tax-credit-calculator/>.

IV. Navigators and Certified Application Counselors

A. Types

1. Navigators are funded through federal grants and have to maintain expertise in eligibility, enrollment and program specifications and conduct public education to increase awareness about the federal exchange. Additional duties include providing information in a fair, accurate and impartial manner, facilitating selection of a qualified health plan, providing referrals for enrollees with grievances or complaints, and providing information that is culturally and linguistically appropriate to the needs of the population being served. In addition, under Wisconsin law, navigators are required to complete 16 hours of prelicensing education, pass a written examination and obtain a navigator license.
2. Certified application counselors are a type of assistance personnel available to provide information to consumers and to help facilitate consumer enrollment into qualified health plans and insurance affordability programs. The federal exchange may designate organizations to certify staff or volunteers to perform these duties. In addition, under Wisconsin law, certified application counselors must complete 16 hours of prelicensing education and pass a written examination.

B. Roles and Responsibilities

Federal regulations set out the definition and eligible entities. Navigators are required to complete federal exchange training and certification. They are expected to provide fair, accurate and impartial information. They need to be familiar with plan eligibility criteria and plan enrollment procedures. Consumers can apply in person, over the telephone, on the Web site or through the mail. Navigators will need to assist consumers in making changes such as adding dependents or changes in income. They need to be aware that consumers on Medicare are not eligible for coverage through the individual exchange. In federal exchange states like Wisconsin, navigators are compensated through federal grant funds and do not receive compensation from insurers or the exchange. Federal regulations prohibit navigators from having conflicts of interest during their terms as navigators. Both navigators and certified application counselors must disclose potential conflicts of interest.

In Wisconsin, licensed navigators and registered certified application counselors are considered to be transacting the business of insurance when functioning within the scope of their license or registration. Activities permitted and prohibited for navigators and certified application counselors include the following:

Permitted Activities:

- Conduct public education activities to raise awareness of available Qualified Health Plans (QHP) within the federal exchange.
- Distribute fair and impartial information concerning enrollment in a QHP through the federal exchange and the availability of premium tax credits and cost-sharing reductions that may be available.
- Explain that consumers may purchase health plans through the federal exchange or off the exchange.
- Make consumers aware that plans are available in the outside market and that they may want to talk with a licensed health insurance agent about health insurance options.
- Facilitate enrollment in a QHP through the federal exchange. Outline information that a consumer will need to have available when applying for coverage through the federal exchange. Provide information that will allow the consumer to access the federal exchange either at their home or a computer terminal provided by the navigator.

- Explain to the consumer the following information: potential eligibility for public/governmental programs; how the federal health insurance premium tax credit and cost-sharing reductions work and risks, if any, for use of the federal health insurance premium tax credit.
- Describe the features and benefits of health coverage in general terms, including cost-sharing mechanisms like deductibles, copays or coinsurance and how these work or affect the consumer.
- Describe what a summary of benefits document is and where to locate a summary of benefits and relevant cost-sharing provisions within the information from QHPs.
- Explain how to find information about provider networks.
- Describe the different metal tiers (i.e., bronze, silver, gold and platinum) and how the benefits may change at different metal tiers based upon the consumer's income.
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the federal exchange.
- Provide a referral for an individual to an appropriate state or federal agency who has a grievance, complaint or question regarding their health plan, coverage, or a determination under such plan or coverage.

Prohibited Activities:

- Receive compensation from an insurer, stop-loss insurance or a third-party administrator.
- Receive compensation that is dependent upon, in whole or in part, whether an individual enrolls in or renews coverage in a health benefit plan.
- Provide any information related to enrollment or other insurance products not offered in the federal exchange.
- Make or cause to be made false or misleading statements.
- Provide advice comparing health benefit plans that may be better or worse for the consumer or employer.
- Recommend a particular health benefit plan or insurer or advise consumers or employers regarding a particular insurer or health benefit plan selection.
- Engage in any fraudulent, deceptive or dishonest acts or unfair methods of competition.
- Receive consideration directly or indirectly from any health insurance issuer in connection with the enrollment of individuals or employees into a QHP.

C. Privacy and Security of Health Information

The Health Insurance Portability and Accountability Act (HIPAA) privacy rule provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the privacy rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes.

The security rule specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity, and availability of electronic protected health information.

Individuals, organizations, and agencies that meet the definition of a covered entity under HIPAA must comply with the rules' requirements to protect the privacy and security of health information and must provide individuals with certain rights with respect to their health information. If a covered entity engages a business associate to help it carry out its health care activities and functions, the covered entity must have a written business associate contract or other arrangement with the business associate that establishes specifically what the business associate has been engaged to do and requires the business associate to comply with the rules' requirements to protect the privacy and security of protected health information. In addition to these contractual obligations, business associates are directly liable for compliance with certain provisions of the HIPAA rules.

If an entity does not meet the definition of a covered entity or business associate, it does not have to comply with the HIPAA rules. Covered entities include health care providers, health plans and health care clearinghouses.

Organizations designated by the federal exchange to provide navigator or certified application counselor services must agree that it and all of its staff members will comply with the privacy and security standards. For all exchanges, including the federally facilitated exchange, the definition for Personally Identifiable Information (PII) is information which can be used to distinguish or trace an individual's identity, alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual. Examples of PII include name, Social Security Number, address, e-mail, and date of birth.

There are two key points to remember about this definition:

1. This definition may be different from definitions provided under other laws. It is important to be familiar with this federal definition and how it applies to exchange information.
2. A key component to the definition is that PII involves information that is linked or linkable to a specific individual. Therefore, if it were possible to link information to an individual, this information would be considered PII, even if it has not yet been linked to that individual.

The key points on the privacy standards and issues are:

- In helping consumers obtain eligibility determinations, compare plans, and enroll in QHPs through the federally facilitated exchange, there may be access to PII.
- PII is information that can be used to distinguish or trace an individual's identity, alone, or when combined with other personal or identifying information that is linked or linkable to a specific individual.
- An exchange may only use or disclose PII as needed to carry out its required functions.
- Tax information is confidential and special rules apply to access and disclosure.

V. Brokers, Agents and Producers

Agents who receive compensation from insurers are not eligible to act as navigators or certified application counselors. Licensed agents can advise consumers and make recommendations regarding plan selection. Agents and brokers can enroll consumers in qualified health plans in the federal exchange if they have registered with the exchange, completed the federal training, and if the agent is appointed with the insurer. Agents and brokers will receive compensation directly from the insurers with whom they have a contractual relationship.

VI. State Public Assistance Programs

A. State Health Care Assistance Programs

1. Medicaid
2. BadgerCare Plus

B. Eligibility

1. Financial requirements
2. Nonfinancial requirements

Additional information regarding State Public Assistance Programs is available on OCI's Web site (oci.wi.gov).

VII. Wisconsin Statutes, Rules and Regulations Common to Life, Disability (Accident & Health), Property and Casualty Insurance

A. Responsibilities of the Commissioner of Insurance

Powers and Duties of the Commissioner

Wisconsin statutory law vests the Commissioner with broad powers and duties to protect the public and to ensure that the insurance industry meets the insurance needs of Wisconsin citizens responsibly and adequately. These powers and duties are exercised in accordance with procedures designed to assure due process and judicial safeguards.

The Commissioner has broad rule-making authority, limited only by the proposed rule's relevance to the related statutes and by general legal and constitutional restraints. The Commissioner supplements statutory law by interpreting that law through the formal processes of rule-making and adjudication, and by informal executive decisions.

Rule-making builds up a body of insurance regulation which is a guide to regulated interests and the general public. The rule-making procedure includes the publishing of proposed rules and an invitation for comment at a scheduled hearing. This procedure permits people to express their opinions about the proposed rule's impact on their businesses, activities, and interests, and helps the Commissioner formulate rules based on sound public policy considerations.

The Commissioner has wide power to issue orders to enforce the statutes and rules. The existence of such enforcement powers enables the Commissioner to negotiate settlements and induce compliance in most instances without the necessity of taking formal disciplinary action. However, the Commissioner will use enforcement powers if the particular situation demands it.

The Commissioner has full administrative power of investigation, usually exercised through investigatory, educational, or multi-purpose hearings.

General Powers

WHAT ARE THE COMMISSIONER'S GENERAL DUTIES AND POWERS?

The Commissioner is responsible for administering and enforcing the insurance laws of Wisconsin. The Commissioner must act as promptly as possible on all matters placed before the office.

The Commissioner and the office possess all the powers specifically granted or reasonably implied by the statutes. This enables the office to perform the duties necessary to enforce the law, including adoption of rules.

[s. 601.41]

MAY THE COMMISSIONER ISSUE ORDERS?

The Commissioner is empowered to issue all prohibitory, mandatory, and other orders as are necessary to secure compliance with the law.

At the request of any person who would be affected by an order, the Commissioner may issue a declaratory order to clarify the person's rights and duties under Wisconsin law.

No rule or order may be issued as a result of a hearing unless the statutory requirements for administrative procedures are met.

[s. 601.41 (4)]

MAY THE COMMISSIONER REQUIRE PERSONS TO SUBMIT REPORTS AND OTHER MATERIAL?

(Persons as used in this context includes individuals, insurers, agencies, and other corporate entities.)

The Commissioner has the authority to require from any person subject to regulation under Wisconsin insurance law:

- Statements, reports, answers to questionnaires, and other information in whatever reasonable form the Commissioner designates and at such reasonable intervals as the Commissioner may choose; and
- Full explanation of the programming of any data processing system, computer, or any other information storage system or communication system in use.

[s. 601.42]

Examination Powers and Duties

WHAT POWER OF EXAMINATION DOES THE COMMISSIONER HAVE?

The Commissioner has the power to examine the affairs and condition of the persons listed below whenever the Commissioner deems it necessary to be informed about any matter related to the enforcement of the insurance laws. These persons include:

- Any licensee under insurance laws (including insurers, intermediaries, corporations, etc.);
- Any applicant for a license;
- Any person or organization transacting, or in the process of organizing to transact, the insurance business in this state;
- Any advisory organization serving any of the above in Wisconsin; and
- Any preclicensing school, continuing education provider, course, or instructor.

[s. 601.43, ss. Ins 26.10, 28.10]

Enforcement Procedures

WHEN ARE HEARINGS REQUIRED?

The Commissioner must hold a hearing before issuing an order or rule whenever the insurance laws or the administrative procedure requirements expressly provide for a hearing. Unless the insurance laws prescribe special procedures, all hearings must comply with the procedures set out in ch. 227, Wis. Stat., and ch. Ins 5, Wis. Adm. Code. The statutes do provide for the summary suspension of an intermediary's or navigator's license if the Commissioner finds that public health, safety, and welfare requires emergency action.

If the intermediary or navigator fails to pay a fee when due, the Commissioner may revoke the license without a hearing. If the Commissioner and the intermediary or navigator agree, an intermediary or navigator may consent to a revocation without a hearing. The Commissioner may revoke the license of a person who

fails to comply with continuing education standards. Otherwise, the Commissioner may revoke, suspend, or limit a permanent license of an intermediary or navigator only after a hearing and an opportunity for judicial review.

The Commissioner must hold a public hearing before adopting any rule unless the rule is procedural rather than substantive, is an emergency rule, or is an exception listed under s. 227.02 of the Administrative Procedure Act.

The Commissioner may hold informal hearings and public meetings for the purposes of investigation, for ascertaining public sentiment, or to inform the public.

[ss. 601.41, 601.62, 628.10, 628.10 (2) (b), ch. 227]

DOES AN APPLICANT FOR AN INTERMEDIARY OR NAVIGATOR LICENSE HAVE A RIGHT TO A HEARING AFTER THE COMMISSIONER'S DECISION NOT TO ISSUE A LICENSE TO THE APPLICANT?

Before being granted an original license, the applicant must show the Commissioner that he or she is competent and trustworthy. Applicants have the right to a hearing to appeal the Commissioner's decision not to issue a license. Such hearing and appeal must comply with the procedures set forth in ch. 227, Wis. Stat.

When an order is issued without a hearing, any aggrieved person may demand a hearing within 30 days after the mailing of the order. Failure to demand a hearing within 30 days constitutes a waiver of the right to a hearing. The demand for a hearing must be made in writing and served on the Commissioner directly or left at the Commissioner's office. The Commissioner must hold the requested hearing not less than 10 days nor more than 60 days after delivery of the request for a hearing.

[s. 601.62, s. Ins 6.59]

WHAT ENFORCEMENT SANCTIONS ARE AVAILABLE TO THE COMMISSIONER?

Whenever a person fails to comply with an order, the Commissioner may start a legal action directing the person to comply with the Commissioner's order and restraining that person from further noncompliance. In addition, forfeitures, civil penalties, and criminal sanctions may be levied by the Commissioner.

[s. 601.64]

WHAT ABOUT FORFEITURES AND CIVIL PENALTIES?

Any person who violates an effective order or any insurance statute or rule may be required to forfeit to the state, in addition to any other forfeiture imposed, twice the amount of any profit gained from the violation.

Any person who violates an order after proper notice may be required to forfeit to the state not more than \$1,000 for each violation. Each day the violation continues constitutes a separate offense.

Any person who violates an insurance statute or rule may be required to forfeit to the state not more than \$1,000 for each violation. If the statute or rule imposes a duty to make a periodic or recurring report to the Commissioner, each week of delay in complying with the duty constitutes a new violation.

[s. 601.64 (3)]

A person who is ordered to pay a forfeiture may demand a hearing. If the person fails to request a hearing, the order is conclusive as to the person's liability. The scope of review for forfeitures is as specified under s. 227.57, Wis. Stat.

[s. 601.64 (3) (d)]

B. Licensing

Chapter 628, Wis. Stat., on insurance law has four main parts: the licensing of insurance intermediaries, regulation of insurance marketing practices, compensation of insurance intermediaries, and the licensing and regulation of navigators and nonnavigator assisters.

The licensing of intermediaries and navigators is concerned solely with the qualifications of the person applying for the insurance license. The essential requirement is that they be trustworthy and competent. The competence includes a basic understanding of fundamental insurance law as well as particular knowledge concerning specific statutes and rules.

Wisconsin insurance statutes outline and define the general requirements which the insurance intermediary must follow. In addition, the insurance intermediary must understand and follow the administrative code which has been adopted by the Commissioner. General statutory language is expanded and clarified—by rule in the administrative code—by describing for agents and companies the practices that are allowed and/or prohibited. The standards of professional conduct set out in the statutes and these rules will be strictly enforced by the Commissioner.

WHAT IS AN INTERMEDIARY?

“Intermediary” means an agent, broker or producer and any person, partnership or corporation requiring a license.

[ch. 628, Wis. Stat.]

A person is an “intermediary” if the person does or assists another in any of the following:

- Soliciting, negotiating, or placing insurance or annuities on behalf of an insurer or a person seeking insurance or annuities; or
- Advising other persons about insurance needs and coverages.

The following persons, however, are not considered “intermediaries” under Wisconsin law:

- A regular salaried officer, employee, or other representative of an insurer or licensed intermediary, who devotes substantially all working time to activities other than those listed immediately above and does not receive any compensation that is directly dependent upon the amount of insurance business obtained;
- A regular salaried officer or employee or a person seeking to procure insurance, who receives no compensation that is directly dependent upon the amount of insurance coverage procured;
- A person who gives incidental advice in the normal course of a business or professional activity other than insurance consulting. Neither the person nor the person’s employer may receive compensation directly or indirectly on account of any insurance transaction that results from such advice;
- A person who, without special compensation, performs incidental services for another at another’s request without providing advice or technical or professional services of the kind normally provided by an intermediary;
- A holder of a group insurance policy, or any other person involved in mass marketing, with respect to the person’s administrative activities in connection with the policy. Such a person may not receive any compensation for the administrative work beyond actual expenses which can be estimated on a reasonable basis;

- A person who provides information, advice, or service for the principal purpose of reducing loss or risk;
- A person who gives advice or assistance without compensation; or
- A representative of a common carrier who sells only over-the-counter, short-term travel accident ticket policies and baggage insurance.

[s. 628.02 (1)]

What Are the Types of Intermediaries?

INTERMEDIARY-INSURANCE AGENT

An intermediary is an insurance agent if the intermediary acts as an intermediary other than as a broker.

[s. 628.02 (4)]

INTERMEDIARY-BROKER

An intermediary is an insurance broker if the intermediary acts in the procuring of insurance on behalf of an applicant for insurance or an insured. An insurance broker does not act on behalf of the insurer except by collecting premiums or performing other ministerial acts.

[s. 628.02 (3)]

WHAT IS A NAVIGATOR?

A navigator can be an individual or an entity that supervises or employs an individual who either performs any activities and duties related to the navigator program on behalf of the federal exchange and who receives funding to perform such functions on behalf of the federal exchange. An individual navigator does not include a person acting as an insurance intermediary.

[s. 628.90]

WHAT REQUIREMENTS MUST A PERSON MEET IN ORDER TO BE ISSUED A NAVIGATOR LICENSE?

Navigators must be licensed and complete 16 hours of prelicensing training, pass a written examination, and meet the following minimum requirements:

- Is at least 18 years of age.
- Resides in this state or maintains his or her principal place of business in this state.
- Has completed the training and course of study requirements and any training and course of study requirements mandated by the federal exchange.
- Has successfully passed a written examination approved by the Commissioner that test the applicant's knowledge concerning the duties and responsibilities of a navigator, the insurance laws and regulations of this state, and state public assistance programs and eligibility.
- Has submitted a full set of fingerprints to the Commissioner and successfully completed a regulatory and criminal history background investigation.

[ss. 628.92, 628.34]

WHAT ARE THE REQUIREMENTS FOR NAVIGATOR LICENSING EXAMINATIONS?

Individual navigator applicants must pass a written examination to become a navigator.

Sixteen hours of prelicensing education is required.

[s. 628.92 (7)]

An applicant who submits an application which meets the competence and trustworthiness standards, pays the required fee, completes the prelicensing education requirements and federal exchange training, and obtains a passing grade on the written examination will be issued a navigator license.

[s. 628.92]

ARE NAVIGATORS REQUIRED TO COMPLETE ANNUAL TRAINING?

Yes. All navigators holding a Wisconsin individual navigator license must complete 8 hours of approved training each year. All credits must be banked by the licensee's expiration date. A credit hour is defined as not less than 50 minutes of classroom instruction by an approved provider. Correspondence, self-study, and on-line courses may be completed if they are approved by meeting criteria under current law and include successful completion of a certified proctored examination.

[s. 628.92 (7)]

WHAT HAPPENS IF NAVIGATORS FAIL TO MEET THE ANNUAL TRAINING REQUIREMENTS?

The Commissioner will notify each individual navigator by mail at least 60 days prior to the reporting date if the navigator is lacking the necessary annual training requirement hours. If the required credit hours are not banked by the reporting date, the license of the navigator will be revoked with notice to the navigator by first class mail.

[s. 628.10 (2) (a)]

CAN A NAVIGATOR REAPPLY WITHOUT COMPLETING PRELICENSING EDUCATION AND TAKING AN EXAMINATION?

Yes. Any individual navigator whose license is revoked for failing to pay renewal fees, failing to complete the required annual training requirement or failing to pay delinquent taxes may, within 12 months, reinstate for the same license without completing prelicensing education or passing a written examination. The individual must have all previous annual training requirements met. If a license has been revoked for more than 12 months, the navigator shall, in order to be relicensed, satisfy the examination and licensing requirements.

[s. 628.10 (5), 628.097 (1m), (2m)]

WHAT IS A CERTIFIED APPLICATION COUNSELOR?

A certified application counselor is a nonnavigator assister who has been designated by or working on behalf of the federal exchange.

[s. 628.90 (4)]

WHAT REQUIREMENTS MUST A CERTIFIED APPLICATION COUNSELOR MEET?

Certified application counselors are required to meet the training and examination requirements established for navigators including the 16 hours of prelicensing training and successful passage of the written examination. This is in addition to any federal training requirements established at 45 CFR 155.225.

[s. 632.896 (2)]

ARE CERTIFIED APPLICATION COUNSELORS REQUIRED TO BE LICENSED?

No. Individuals who want to become certified application counselors do not need to be licensed. Entities employing one or more nonnavigator assisters are required to provide the Commissioner with a list of all certified application counselors that it employs, supervises or is affiliated with once the individuals are authorized by the federal exchange to provide assistance. Entities employing, supervising or affiliated with certified application counselors assume legal responsibility for the acts of the certified application counselors.

[s. 628.96 (1) (3)]

ARE CERTIFIED APPLICATION COUNSELORS REQUIRED TO COMPLETE ANNUAL TRAINING?

Yes. Certified application counselors are required to complete 8 hours of annual training.

[s. 628.96 (2)]

ARE THERE SPECIAL REQUIREMENTS FOR THE DISPOSAL OF PERSONAL MEDICAL INFORMATION?

Yes. Insurers and agents that obtain information from an insured or an individual seeking coverage, pertaining to the person's physical or mental health, medical history, or medical treatment, must take specific steps to ensure that personally identifiable information (PII) is shredded, erased, modified or otherwise handled so that no unauthorized person has access to the information.

[s. 134.97]

WHAT IS HOME SOLICITATION SELLING?

Home solicitation selling means the solicitation or the offering for sale of insurance where the solicitation or sale is made by an agent at the residence or place of business or employment of the buyer or away from the agent's regular place of business. Home solicitation selling includes solicitations made directly or indirectly by telephone, person to person contact, or by written or printed communication, other than general advertising that indicates an intent to sell insurance or services at a regular place of business.

[s. Ins 20.01 (3) (c)]

ARE THERE CERTAIN DISCLOSURES THAT MUST BE MADE BY AN AGENT ENGAGED IN HOME SOLICITATION SELLING?

Yes. When engaged in home solicitation selling, every seller shall, at the time of initial contact or communication with an actual or prospective purchaser of insurance, clearly and expressly disclose the seller's individual name, the name of the business firm or organization represented, a statement that insurance is being sold or solicited, the identity of the insurer, if the solicitation is primarily for a single insurer, and the type of insurance being solicited.

A seller means a person, insurance agent, representative, insurance intermediary or organization engaged in home solicitation selling, advertising or offering services in home solicitation selling, or providing or exercising supervision, direction, or control over sales practices used in home solicitation sales.

A seller who receives a check or cash shall give the buyer a receipt or other document of the transaction which includes the date of the sale, a description of the type of policy applied for, price paid, the name of the seller, and the name and mailing address of the insurer issuing the policy.

Persons engaging in home solicitation selling shall not:

- Represent directly or by implication that the seller is making an offer to specially selected persons unless such representations are true and the specific basis for such representations is stated at the time the representation is made.

- Represent that the seller is conducting a survey, test or research project or engaged in a contest or other venture to win a cash award, scholarship, vacation, or similar prize when the principal objective is to make an insurance sale or obtain information to help identify sales prospects.
- Use any false, deceptive or misleading representations to induce a sale, or use any plan, scheme or ruse which misrepresents that the person making the call is selling insurance, or fail to leave the premises promptly when requested to do so.

[s. Ins 20 .01]

WHAT REGULATION CHARGES MUST A LICENSED NAVIGATOR PAY?

The annual regulation amount to be paid by each licensed individual navigator is \$35.00. Notification of the annual regulation charge will be mailed by first class mail to the mailing address on file with the Commissioner at least 60 days prior to the due date. If the fee is not paid by the expiration date, the navigator's license is revoked.

[s. 601.31 (1) (n) (m), s. 628.10 (2) (a)]

HOW LONG DOES A NAVIGATOR LICENSE REMAIN IN EFFECT?

An navigator's license remains in effect until it is revoked, suspended, or limited by the Commissioner; until it is voluntarily surrendered by the navigator; until the death of the navigator; until a court's finding that the navigator is mentally incompetent; or until the Commissioner finds, after a hearing, that the person, corporation, or partnership is no longer qualified to act as an navigator.

[s. 628.10 (1)]

WHEN CAN A NAVIGATOR LICENSE BE REVOKED, SUSPENDED OR LIMITED?

The license of an individual navigator who fails to pay a fee or fails to complete the annual training requirements when due is revoked as of the date due if the Commissioner gave the navigator reasonable notice. The navigator may be relicensed only after satisfying all requirements under s. 628.92, Wis. Stat.

[s. 628.10 (2)]

IF A LICENSE HAS BEEN REVOKED, WHEN CAN THE NAVIGATOR REAPPLY?

If a license is revoked for nonpayment of fees or failure to comply with the annual training requirements, the individual navigator may reinstate immediately after paying the required fee and/or completing the annual training requirement.

When the Commissioner revokes an individual navigator license for any of the other reasons mentioned in the preceding section, the Commissioner may specify a time period of five years or less during which the navigator may not apply for a new license. If the Commissioner does not specify a time period, the navigator may not apply for five years.

[s. 628.10 (3)]

C. Marketing Practices

WHAT MARKETING PRACTICES ARE UNFAIR?

Unfair marketing practices include: misrepresentation; unfair inducements; unfair discrimination; restraint of competition, unfair restriction of contracting parties' choice of insurer; extra charges; attempt to unduly influence employers; and unfair use of official position.

[s. 628.34, ss. Ins 6.54, 6.55]

WHAT IS MISREPRESENTATION?

It is a violation for intermediaries and their employees or those acting on their behalf to make any written or oral communication about any insurance contract, the insurance business, any insurance company, or any agent which contains false or misleading information. This includes:

- Information which is misleading because of incompleteness;
- Filing a report with the intent to deceive the person examining that report;
- Making a false entry in a record;
- Failure to make a proper entry in a record for the purpose of concealing information; and
- Using the name, slogan, emblem, or related device which will or is likely to cause an intermediary to be mistaken for another intermediary in the insurance business. If an insurance intermediary distributes cards or documents, exhibits signs, or publishes advertisements which include misrepresentations and contain reference to a particular insurer that the person represents as agent, the intermediary's violation carries a presumption that the violation was also committed by the insurer.

[s. 628.34 (1)]

WHAT IS RESTRAINT OF COMPETITION?

It is illegal for any of the following persons to commit or agree to take part in any act of boycott, coercion, or intimidation which tends to unreasonably restrain the business of insurance, or which tends to create a monopoly in the insurance business:

- A person who is or should be licensed in Wisconsin;
- A person who is an employee or agent of the person who is or should be licensed in Wisconsin;
- A person whose main interest is to compete in the same business as those persons who are or should be licensed in Wisconsin;
- A person who acts on behalf of those persons mentioned in the preceding sections.

[s. 628.34 (4)]

MAY A PERSON'S CHOICE OF INSURER BE RESTRICTED BY ANOTHER?

No one who requires insurance coverage as a condition for concluding a contract or for exercising any right under a contract may restrict the choice of insurer of the person buying the coverage. The person who is requiring the coverage may reserve the right to disapprove, on reasonable grounds, the policy or insurance company selected. The form of the corporate organization of the insurance company is not a reasonable ground for disapproval.

[s. 628.34 (5)]

ARE THERE ADDITIONAL RULES DEFINING UNFAIR MARKETING PRACTICES?

Yes. The Commissioner may define by administrative rule specific unfair trade practices after a finding that the practices are misleading, deceptive, unfairly discriminatory, provide an unfair inducement, or restrain competition unreasonably.

[s. 628.34]

WHAT EFFECT DOES THE INTERMEDIARY'S APPOINTMENT HAVE ON THE INSURER?

Every insurer is bound by an act of its agent performed in Wisconsin that is within the scope of the agent's authority. The insurance company remains bound while the agency contract is in force or until the insurance company has made reasonable efforts to recover from the agent its policy forms and other indicia of the agency. Reasonable efforts shall include a formal demand in writing for return of the indicia, and notice to the Commissioner if the agent does not comply with the demand promptly.

[s. 628.40]

Compensation of Agents

MAY AN AGENT RECEIVE COMPENSATION FROM AN INSURED OR FROM AN INSURED AND ANOTHER SOURCE FOR THE PURCHASE OF INSURANCE OR FOR RENDERING ADVICE ON INSURANCE NEEDS AND COVERAGES?

Yes, an agent may accept compensation under these circumstances. However, the agent must disclose to the applicant in writing:

- The amount of compensation to be paid by the insured (other than a commission payment made by the insurer); and
- The fact, if applicable, that compensation will be paid by another source.

[s. 628.32]

WHAT ARE PROHIBITED PRACTICES FOR NAVIGATORS OR CERTIFIED APPLICATION COUNSELORS?

Licensed navigator and registered nonnavigator assisters are considered to be transacting the business of insurance when functioning within the scope of their license or registration. Activities permitted and prohibited for navigators and nonnavigator assisters include the following:

Permitted Activities:

- Conduct public education activities to raise awareness of available Qualified Health Plans (QHP) within the federal exchange.
- Distribute fair and impartial information concerning enrollment in a QHP through the federal exchange and the availability of premium tax credits and cost-sharing reductions that may be available.
- Explain that consumers may purchase health plans through the federal exchange or off the exchange.
- Make consumers aware that plans are available in the outside market and that they may want to talk with a licensed health insurance agent about health insurance options.
- Facilitate enrollment in a QHP through the federal exchange. Outline information that a consumer will need to have available when applying for coverage through the federal exchange. Provide information that will allow the consumer to access the federal exchange either at their home or a computer terminal provided by the navigator.
- Explain to the consumer the following information: potential eligibility for public/governmental programs; how the federal health insurance premium tax credit and cost-sharing reductions work and risks, if any, for use of the federal health insurance premium tax credit.

- Describe the features and benefits of health coverage in general terms, including cost-sharing mechanisms like deductibles, copays or coinsurance and how these work or affect the consumer.
- Describe what a summary of benefits document is and where to locate a summary of benefits and relevant cost-sharing provisions within the information from QHPs.
- Explain how to find information about provider networks.
- Describe the different metal tiers (i.e., bronze, silver, gold and platinum) and how the benefits may change at different metal tiers based upon the consumer's income.
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the federal exchange.
- Provide a referral for an individual to an appropriate state or federal agency who has a grievance, complaint or question regarding their health plan, coverage, or a determination under such plan or coverage.

Prohibited Activities:

- Receive compensation from an insurer, stop-loss insurance or a third-party administrator.
- Receive compensation that is dependent upon, in whole or in part, whether an individual enrolls in or renews coverage in a health benefit plan.
- Provide any information related to enrollment or other insurance products not offered in the federal exchange.
- Make or cause to be made false or misleading statements.
- Provide advice comparing health benefit plans that may be better or worse for the consumer or employer.
- Recommend a particular health benefit plan or insurer or advise consumers or employers regarding a particular insurer or health benefit plan selection.
- Engage in any fraudulent, deceptive or dishonest acts or unfair methods of competition.
- Receive consideration directly or indirectly from any health insurance issuer in connection with the enrollment of individuals or employees into a QHP.

Any individual or entity acting in violation of the newly enacted law provisions may be subject to an administrative action including restitution and limitation or revocation of licensure or registration.

[s. 628.95]

D. General Statutes, Rules, and Regulations Affecting Insurance Contracts

Insurance Contracts Generally

This section covers insurance contracts in general. The state statutes affecting this material (chs. 631 and 632, Wis. Stat.) set out minimal standards for regulating the terms of insurance contracts. Control over policy forms and provisions is necessary for the adequate protection of Wisconsin policyholders. The approach

of these statutes is to establish explicit standards within which the intermediary and the insurer will have sufficient freedom to develop contract terms and alternatives that fill the needs of individual consumers.

General Rules

DO CHS. 631 AND 632, WIS. STAT. (the "Contracts" chapters), APPLY TO ALL KINDS OF INSURANCE?

The laws and regulations in these chapters apply to all insurance policies delivered or issued for delivery in this state on:

- Persons residing in Wisconsin when the policy is issued;
- Property ordinarily located in Wisconsin; or
- Business operations in Wisconsin.

[s. 631.01 (1)]

IS AN INSURANCE COMPANY RESPONSIBLE FOR INFORMATION KNOWN TO ITS AGENTS?

An insurance company is deemed to know any fact material to the risk or which violates a condition of the policy:

- If the insurance company's agent who bound the company, issued the policy or transmitted the application to the insurer knew the fact at the time he or she acted; or
- If afterwards any of the company's agents learned of the fact during the course of dealing with the policyholder as an agent and knew that the fact pertained to the policy.

[s. 631.09 (1)]

IS NOTICE TO AN AGENT NOTICE TO THE INSURANCE COMPANY?

Yes. The insurance company has been notified if the company's authorized agent has been notified by or on behalf of the policyholder or insured and provided with sufficient information to identify the policy in question.

[s. 631.09 (3)]

HOW IS THE INSURER PROTECTED FROM COLLUSION BETWEEN THE POLICYHOLDER AND AGENT?

If the agent and policyholder or insured acted together to deceive or defraud the insurance company, the sections on knowledge of the insurance company and acts of agents do not apply. The two sections also do not apply if the policyholder or the insured knew the agent was acting beyond the scope of the agent's authority.

[s. 631.09 (4)]

WHAT IS A REPRESENTATION BY AN APPLICANT?

Representations are oral or written statements made by an applicant. Insurance coverage is issued on the basis of the applicant's representations.

[Common Law, s. 631.11]

WHAT IS MISREPRESENTATION BY AN INTERMEDIARY?

Misrepresentation by an intermediary is the use of written or oral statements which incorrectly describe the terms or benefits of any policy.

[Common Law, s. 631.11]

WHAT IS A MATERIAL MISREPRESENTATION BY AN APPLICANT?

A material misrepresentation is an untrue statement made by an applicant that would influence a prudent insurer in determining whether to accept the risk or in fixing the amount of the premium in the event of such acceptance.

[Common Law, s. 631.11]

WHAT IS A WARRANTY?

A warranty is a statement made in an insurance contract by the insured when the validity of the insurance contract depends on the literal truth of the statement. The parties to the contract mutually intend that the policy will not be binding unless the statement is true.

[Common Law, s. 631.11]

WHAT IS AN AFFIRMATIVE WARRANTY?

An affirmative warranty is an express or implied positive representation in the policy which affirms an existence of a fact at the time the policy was entered into.

[Common Law, s. 631.11]

WHAT IS A PROMISSORY WARRANTY?

A promissory warranty is a warranty that certain things will be done or not be done after the policy has taken effect.

[Common Law, s. 631.11]

WHEN DOES A STATEMENT, REPRESENTATION, OR WARRANTY AFFECT THE INSURER'S OBLIGATIONS UNDER A POLICY?

No statement, representation, or warranty made by a person other than the insurer or an agent of the insurer in the negotiation for an insurance contract affects the insurance company's obligations under the policy unless it is stated in any of the following:

1. The policy.
2. A written application signed by the person provided that a copy of the written application is made a part of the policy by attachment or endorsement.
3. A written communication provided by the insurer to the insured within 60 days after the effective date of the policy.

[s. 631.11 (1) (a)]

MUST A COPY OF THE APPLICATION BE MADE AVAILABLE TO THE INSURED?

The policyholder under disability (accident & health) insurance policy and any person whose health is insured under the policy may request in writing a copy of the application if he or she did not receive the policy or a copy of it. The request may also be made if the policy has been reinstated or renewed without

attachment of a copy of the original application. If the insurance company does not deliver or mail a copy as requested within 15 working days after the company or its agent receives the request, nothing in the application may affect the insurance company's obligations under the policy to the person making the request. The same conditions and results apply where a group policy certificate holder is not informed by the insurer how such person may inspect the policy and application during normal business hours at a place reasonably convenient to the certificate holder.

[s. 631.11 (4m) (a)]

WHAT IS THE EFFECT OF A MISREPRESENTATION OR BREACH OF AN AFFIRMATIVE WARRANTY ON THE INSURER'S OBLIGATIONS?

No misrepresentation, and no breach of an affirmative warranty, that is made by a person other than the insurer or an agent of the insurer in the negotiation for or procurement of an insurance contract constitutes grounds for rescission of, or affects the insurer's obligations under, the policy unless, if a misrepresentation, the person knew or should have known that the representation was false, and unless any of the following applies:

- The insurer relies on the misrepresentation or affirmative warranty and the misrepresentation or affirmative warranty is either material or made with intent to deceive.
- The fact misrepresented or falsely warranted contributes to the loss.

[s. 631.11 (1) (b)]

WHAT EFFECT DOES THE INSURER'S KNOWLEDGE HAVE ON ITS OBLIGATIONS?

No misrepresentation made by or on the behalf of a policyholder and no breach of an affirmative warranty or failure of a condition constitutes grounds for rescission of, or affects an insurer's obligations under, an insurance policy if at the time the policy is issued the insurer has either constructive knowledge of the facts [under s. 631.09 (1), Wis. Stat.] or actual knowledge. If the application is in the handwriting of the applicant, the insurer does not have constructive knowledge under s. 631.09, Wis. Stat., merely because of the agent's knowledge.

[s. 631.11 (4) (a)]

If after issuance of an insurance policy an insurer acquires knowledge of sufficient facts to constitute grounds for rescission of the policy under this section or a general defense to all claims under the policy, the insurer may not rescind the policy and the defense is not available unless the insurer notifies the insured within 60 days after acquiring such knowledge of its intention to either rescind the policy or defend against a claim if one should arise, or within 120 days if the insurer determines that it is necessary to secure additional medical information.

[s. 631.11 (4) (b)]

WHAT ARE THE PRIVACY PROTECTIONS UNDER WISCONSIN INSURANCE LAW?

Wisconsin consumers are provided with privacy protection for medical and financial information. These laws correspond with the requirements under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Gramm-Leach-Bliley Act (GLB) enacted in 1999. Chapter Ins 25, Wis. Adm. Code, addresses insurance agents' responsibilities when sharing consumer and customer private personal financial and health information with third parties. The administrative code requires that a licensee provide written notice of its privacy policies and practices. It also establishes requirements for privacy notices. Insurance agents may, for the most part, rely on the insurance companies with which they are listed to provide the required notices and disclosure. However, insurance agents who perform activities in

addition to marketing products for insurance companies or who share client personal information may be responsible for obtaining authorization and providing notice to clients who meet the definition of consumers and customers.

[ch. Ins 25]

WHAT ARE THE MEDICAL RECORDS PRIVACY PROTECTIONS UNDER WISCONSIN INSURANCE LAW?

Wisconsin enacted a statute that regulates the disclosure of personal medical information. It places restrictions on both insurers and the persons that regularly assemble or collect personal medical information for the primary purpose of providing the personal medical information to insurers for the determination of an individual's eligibility for an insurance coverage, benefit or payment or for the servicing of an insurance application, policy or certificate. The law delineates the form that is to be used in obtaining authorization for release of personal medical information, the timeframe for which such information may be requested and maintained, how and to whom information may be released to other entities or health care providers, notice requirements to individuals or insureds and the right of the individual to request a correction, amendment or deletion of personal medical information that is in the insurer's possession.

[s. 610.70]

WHAT ARE THE PRIVACY PROTECTIONS REGARDING NONPUBLIC PERSONAL FINANCIAL INFORMATION UNDER WISCONSIN INSURANCE LAW?

Wisconsin enacted rules that require insurance companies and agents to provide written notice of its privacy policies and practices. The rule describes the conditions under which insurance companies and their agents may disclose nonpublic personal financial information. The rule also establishes requirements for privacy notices.

The rule also establishes restrictions on the sharing of health information. However, as Wisconsin has a separate statute regarding Medical Records Privacy, the provisions of the rule apply primarily to health information relating to claimants against worker's compensation or commercial liability insurance policies.

[ch. Ins 25]

WHEN ARE AGENTS REQUIRED TO PROVIDE PRIVACY NOTICES?

Agents can rely on the notice procedures of the insurance companies they represent as long as the agent does not share the nonpublic personal information as provided by the rule. If the agent shares the information with third parties in activities that are not excepted by the rule, the agent will be required to issue the same type of notices required of the insurer.

[ch. Ins 25]

DISPOSAL OF RECORDS CONTAINING PERSONAL INFORMATION

Wisconsin statutes include provisions regarding the proper disposal of personal medical information. The law is often referred to as the "dumpster diving law." It requires that insurers that obtain information from an insured, or an individual seeking coverage, pertaining to the individual's physical or mental health, medical history or medical treatment take specific steps to ensure that this personally identifiable information is shredded, erased, modified or otherwise handled so that no unauthorized person has access to the information.

[s. 134.97]

Use of Policy Forms

MAY ANY INSURANCE POLICY FORM BE USED IN WISCONSIN?

Unless specifically exempt under the statutes, no policy form may be used in Wisconsin unless it has been filed with the Commissioner.

[s. 631.20]

WHAT ARE THE READABILITY STANDARDS FOR INSURANCE POLICIES?

A rule relating to the readability of insurance policies went into effect in Wisconsin in 1980. The rule implements s. 631.22, Wis. Stat.

The rule applies to consumer insurance policies issued or delivered in Wisconsin. Consumer insurance policies are defined as life, disability (accident & health), property or casualty policies and certificates or substitutes for certificates for group life, disability (accident & health), property or casualty insurance coverage, issued for family, personal, or household purposes. There are some exemptions.

When policies subject to the rule are submitted for filing or approval, they must be accompanied by a certification stating that the policy meets the minimum standards.

[s. 631.22, s. Ins 6.07]

MUST INSURERS NOTIFY POLICYHOLDERS OF THEIR RIGHT TO FILE A COMPLAINT?

Yes. Insurers are required to notify their insureds of their right to file a complaint with the Office of the Commissioner of Insurance regarding problems they may have with their insurance. The notice is required once for each policy or certificate issued by an insurer.

[s. 631.28, s. Ins 6.85]

E. Regulation of Specific Clauses in Insurance Contracts

Insurance Claims

WHAT NOTICE AND PROOF OF LOSS REQUIREMENTS APPLY TO THE INSURED?

If a proof of loss is furnished to the insurer as soon as reasonably possible and within one year after the time it was required by the policy, failure to furnish such notice or proof within the time required by the policy does not invalidate or reduce a claim unless the insurer is harmed as a result and it was reasonably possible to meet the time limit.

The notice or proof of loss is sufficient if it is properly mailed to the insurer within the time prescribed. The Commissioner may expressly approve clauses requiring more prompt and efficient methods of notice where that is reasonable.

The acknowledgment by the insurer of the receipt of notice, the furnishing of forms for filing proofs of loss, the acceptance of such proofs, or the investigation of any claim is not alone sufficient to waive any of the rights of the insurer in defense of any claim arising under the insurance contract.

[s. 631.81]

ARE THERE STANDARDS FOR INSURANCE CLAIM SETTLEMENT PRACTICES?

Wisconsin law regulates insurance claim settlement practices in order to promote the fair and equitable treatment of policyholders, claimants, and insurers by defining certain claim adjustment practices as unfair business methods and practices in the insurance business.

[s. 628.46, s. Ins 6.11]

HOW PROMPTLY MUST CLAIMS BE PAID?

Unless otherwise provided by Wisconsin law, subject to interest payment, an insurer must promptly pay most insurance claims. A covered claim is overdue if not paid within 30 days after the insurer is furnished with a written notice of the fact of covered loss and the amount of loss.

If the written notice of the entire claim is not sent to the insurer, any partial amount supported by written notice is overdue if not paid within 30 days. A payment is not overdue if the insurer has reasonable proof to establish that the insurer is not responsible for the payment, even when written notice has been furnished to the insurer.

The date of payment is the date a check or payment was properly mailed or, if not mailed, the date of delivery of the payment. All overdue payments are charged simple interest at the rate of 12% per year.

The payment of a claim is not overdue until 30 days after the insurer receives the proof of loss required under the policy or equivalent evidence. Also, a delay in payment may be justified if the insurer cannot determine to whom the claim should be paid.

[s. 628.46]

WHAT ARE SOME EXAMPLES OF UNFAIR CLAIM SETTLEMENT METHODS AND PRACTICES?

Any of the following done without just cause and with such regularity as to indicate a general business practice, constitute an unfair method and practice:

[s. Ins 6.11 (3) for additional examples]

- Failure to promptly acknowledge pertinent communications with respect to claims arising under insurance policies;
- Failure to promptly provide the necessary claim forms, instructions, and reasonable assistance to insureds and claimants;
- Failure to attempt in good faith to effectuate fair and equitable settlements of claims in which liability has become reasonably clear;
- Knowingly misrepresenting to claimants pertinent facts or policy provisions.

[s. Ins 6.11]

VIII. Wisconsin Statutes, Rules, and Regulations Pertinent to Disability (Accident & Health) Insurance Only

Disability (Accident & Health) Insurance

Disability (accident & health) insurance, previously labeled as “accident and health” insurance, is generally defined as any type of insurance that covers policy claims involving: (1) medical and surgical expenses; (2) indemnities for loss of income due to accident or health; (3) accidental death and disability (accident & health); (4) hospital care; and (5) long-term care.

Most disability (accident & health) policies offer a wide range of coverages and limits. The Commissioner has the authority to regulate the terms of insurance contracts to protect the policyholder. The insurance laws establish statutory standards, explicit enough to protect the insured and to give the Commissioner authority to set specific standards and provisions through rule-making powers.

A. Policy Provisions

DOES A POLICYHOLDER WITH AN INDIVIDUAL DISABILITY (ACCIDENT & HEALTH) INSURANCE CONTRACT HAVE A “RIGHT TO RETURN” THE POLICY ONCE IT HAS BEEN ISSUED?

A policyholder may return any individual disability (accident & health) policy within 10 days after receiving it. If the policyholder returns the policy within the 10-day period, the insurance contract is invalid and all payments made under the contract must be refunded.

The “right to return” must be printed on or attached to the first page of each individual policy.

This “right to return” does not apply to single premium nonrenewable policies issued for terms not greater than six months or accident-only policies.

[s. 632.73]

MAY AN INSURER CONTEST A DISABILITY (ACCIDENT & HEALTH) POLICY ON THE GROUND THAT THE INSURED MADE A MISREPRESENTATION?

Disability (accident & health) policies are incontestable once they have been in force for two years. This means that statements made by an applicant in an application attached to an individual disability (accident & health) insurance policy may not be the basis for voiding a policy, or denying a claim for loss incurred or disability beginning after coverage has been in effect for two years. The contract may provide for a shorter period of contestability. Fraudulent misrepresentation constitutes a valid ground for voiding the policy, regardless of the length of time the policy has been in effect. The policy may provide for incontestability even with respect to fraudulent misstatements.

[s. 632.76 (1)]

WHAT IS PORTABILITY?

An insurer must reduce a preexisting condition waiting period under a group health benefit plan by the aggregate of an employee’s or dependent’s periods of creditable coverage on the individual’s enrollment date under the employer’s plan. Creditable coverage means coverage under a group health plan, health benefit plan, Medicare, Medicaid, a health plan offered under chapter 89 of title 5 or chapter 55 of title 10 of the United States Code, a state health benefits risk pool, a public health plan, a health plan under the federal Peace Corps Act, or a medical care program of the federal Indian health service or of an American

Indian tribal organization. Periods of creditable coverage after which the individual was not covered under any creditable coverage for a period of at least 63 days before enrollment in the employer's plan may not be counted. Any waiting period or affiliation period for coverage under the employer's plan may not be counted in determining the period before enrollment in the employer's plan.

An insurer offering a group health benefit plan must count a period of creditable coverage without regard to the specific benefits for which the individual had coverage during the period, unless the insurer elects to reduce the preexisting condition waiting period by the amount of time the individual had prior creditable coverage within each of several classes or categories of benefits. These categories of benefits are limited to prescription drug, dental, vision, mental health, and substance abuse treatment.

This election must be made on a uniform basis for all individuals. Insurers electing the second option must count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category. Insurers must also prominently state in any disclosure statements concerning coverage and to each employer at the time of the offer or sale of coverage that the insurer has elected the second option and what the effect of that election will be.

[s. 632.746 (3)]

HOW DO INDIVIDUALS PROVE THEY HAVE CREDITABLE COVERAGE?

Insurers that provide health benefit plan coverage must provide a written certification of creditable coverage when an individual ceases to be covered under a health benefit plan, when an individual becomes covered under COBRA continuation coverage, and when an individual ceases to be covered under COBRA continuation. Insurers must also provide a certification upon the request of an individual that is made no later than 24 months after the date the individual's coverage ceases, or the date the individual's COBRA continuation begins or ceases, whichever is later. The certification must include information concerning the individual's period of creditable coverage; the coverage, if any, under COBRA; and the waiting period, if any, under the individual's health benefit plan.

[s. 632.746 (4)]

WHAT GRACE PERIODS ARE REQUIRED IN INDIVIDUAL DISABILITY (ACCIDENT & HEALTH) INSURANCE POLICIES FOR LATE PREMIUM PAYMENTS?

Every disability (accident & health) insurance policy with weekly premiums must contain a provision for a grace period of at least 7 days. Policies with monthly premiums must provide for a grace period of at least 10 days. All other policies require a 31-day grace period. These grace periods apply only to the premiums that follow the initial premium payment. A policy continues in effect during the grace period.

[s. 632.78 (1)]

WHAT IS A GRIEVANCE?

A grievance is any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured including:

- Provision of services.
- Determination to reform or rescind a policy.
- Determination of diagnosis or level of service required for evidence-based treatment of autism spectrum disorders.
- Claim practices.

[s. Ins 18.01 (4)]

WHAT TYPE OF HEALTH POLICIES MUST DEVELOP AN INTERNAL GRIEVANCE PROCEDURE?

All insurers that issue health benefit plans must develop an internal grievance procedure. Health benefit plans do not include accident only or disability income insurance. Insurers are required to file with the OCI an annual grievance report.

[ss. 632.745 (11), 632.83, s. Ins 18.02 (1)]

WHAT IS AN INDEPENDENT REVIEW?

The independent review process provides an insured with an opportunity to have medical professionals who have no connection to their health plan review a dispute. The independent review organization (IRO) assigns the dispute to a clinical peer reviewer who is an expert in the treatment of the disputed medical condition. The IRO has the authority to determine whether the treatment should be covered by the health plan.

[s. 632.835, s. Ins 18.01 (6)]

IS THERE A COST TO THE INSURED?

No, there is no cost to the insured. The health plan is required to pay the IRO's total fees.

[s. 632.835, s. Ins 18.11 (2) (a) 4.]

B. Coverages

MUST INSURERS PROVIDE COVERAGE FOR NURSE PRACTITIONERS?

Insurers or self-funded municipalities or self-funded school districts cannot refuse to provide coverage for certain specified tests, examinations, or associated laboratory fees when performed by a nurse practitioner if the policy would provide coverage for the same services when performed by a physician.

[s. 632.87 (5)]

MUST INSURERS PROVIDE COVERAGE FOR OPTOMETRISTS?

Insurers may not, under a contract or plan covering vision care services or procedures, refuse to provide coverage for such services provided by an optometrist if the contract or plan includes coverage for the same services or procedures when provided by another health care practitioner.

[s. 632.87 (2)]

MUST INSURERS PROVIDE COVERAGE FOR CHIROPRACTIC BENEFITS?

Insurers must include coverage of services by a licensed chiropractor for diagnosis and treatment of a condition or complaint within the scope of the chiropractor's professional license if the policy covers diagnosis and treatment of the condition or complaint by a licensed physician or osteopath. Medicare supplement policies cover the usual and customary expense for services provided by a chiropractor. This benefit is available even if Medicare does not cover the claim. Insurers are prohibited from:

- Restricting or terminating chiropractic coverage on the basis of an examination or evaluation other than by a chiropractor or peer review panel containing a chiropractor;
- Establishing underwriting standards that are more restrictive for chiropractic care than for care provided by other health care providers;
- Refusing to provide coverage to an individual because the individual has been treated by a chiropractor; or

- Excluding or restricting health care coverage of a health condition solely because the condition may be treated by a chiropractor.

Claims for chiropractic services must be paid within 30 days after the insurer receives clinical documentation from the chiropractor unless, on the basis of an independent evaluation, an insurer restricts or terminates a patient's coverage for treatment.

[s. 632.87 (3)]

WHAT STANDARDS APPLY TO COVERAGE OF EMERGENCY MEDICAL SERVICES?

An insurer that provides coverage of any emergency medical services may not deny coverage for emergency services that a reasonably prudent person would consider an emergency, and that are required to evaluate or stabilize the patient. An insurer can also not require prior authorization for emergency services.

[s. 632.85]

WHAT RESTRICTIONS APPLY TO INSURERS WHO ONLY PROVIDE COVERAGE OF CERTAIN PRESCRIPTION DRUGS AND DEVICES?

Insurers that use a formulary or other list of preapproved drugs and devices must have a process to permit a physician to request an individual exception for coverage of a drug or device not normally covered under the plan.

[s. 632.853, s. Ins 3.67 (2)]

WHAT REQUIREMENTS PERTAIN TO COVERAGE FOR EXPERIMENTAL TREATMENT?

Insurers that limit coverage for experimental treatment must disclose such limitations in its policies and certificates and have a procedure for handling requests for prior authorization of an experimental procedure. Insurers must issue a coverage decision on a request for experimental treatment within five working days of receiving the request. Insurers must also have a procedure to allow an insured to appeal a denial of coverage for an experimental treatment.

[s. 632.855, s. Ins 3.67 (3)]

ARE THERE SPECIAL RIGHTS FOR HANDICAPPED CHILDREN COVERED BY DISABILITY (ACCIDENT & HEALTH) POLICIES?

Hospital or medical expense policies that cover the dependent children of an insured may end coverage when the child reaches the age stated in the contract. However, coverage of a dependent child cannot be ended while the child continues to be both:

- Incapable of self-sustaining employment because of mental retardation or physical handicap; and
- Chiefly dependent upon the person insured under the policy for support and maintenance.

[s. 632.88]

WHAT COVERAGE MUST BE PROVIDED FOR DEPENDENTS OF AN APPLICANT OR INSURED?

Insurers or self-funded municipalities or self-funded school districts must offer and, if so requested by an applicant or an insured, provide coverage for an adult child as a dependent of the applicant or insured if the child is over 17 but less than 26 years of age.

The coverage requirement also applies to an adult child who is a full-time student and called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while attending an

institution of higher education on a full-time basis, and under the age of 27 when called to federal active duty.

[s. 632.885]

WHAT BENEFITS ARE EMPLOYERS WITH FEWER THAN 10 EMPLOYEES THAT ELECT TO BE EXEMPT REQUIRED TO PROVIDE FOR ALCOHOLISM, DRUG ABUSE, AND MENTAL AND NERVOUS DISORDERS?

HMOs are required to provide certain benefits for outpatient treatment of nervous and mental disorders, alcoholism, and other drug abuse to a dependent student who is attending a school of higher education located in this state but outside the HMO's service area, if the HMO would have provided benefits for such services by a selected provider within the service area.

[ss. 609.05 (3), 609.655]

WHAT BENEFITS MUST BE PROVIDED FOR HOME CARE?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, providing coverage of expenses incurred for inpatient hospital care must provide coverage for no less than 40 home health care visits in any 12-month period for each person covered under the policy. Home health care means the care and treatment of an insured under a plan of care established by the attending physician, which may include intermittent home nursing care, home health aide services, various types of therapy, medical supplies and medication prescribed under the home care plan, and nutrition counseling. If an insurer provides disability (accident & health) insurance, or if two or more insurers jointly provide disability (accident & health) insurance, to an insured under two or more policies, home health care coverage is required under only one of the policies.

Insurers may not deny coverage of a home health care claim based solely on Medicare's denial of benefits.

Insurers must disclose and clearly define the home care benefits and limitations in a disability (accident & health) insurance policy, certificate, and outline of coverage.

[s. 632.895, s. Ins 3.54]

WHAT BENEFITS MUST BE PROVIDED FOR SKILLED NURSING CARE?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, that covers hospital expenses must provide coverage for at least 30 days for skilled nursing care to patients who enter a licensed skilled nursing care facility. Coverage may be limited to care that is certified as medically necessary by the attending physician. A disability (accident & health) insurance policy other than a Medicare supplement or Medicare replacement policy may limit coverage to patients who enter a licensed skilled nursing care facility within 24 hours after discharge from a hospital to receive continued care that is for the same condition as treated in the hospital.

[s. 632.895 (3)]

WHAT BENEFITS MUST BE PROVIDED FOR KIDNEY DISEASE TREATMENT?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, that covers hospital expenses must provide coverage for hospital inpatient and outpatient treatment of kidney disease, which may be limited to dialysis, transplantation, and donor-related services. The coverage is not required to duplicate Medicare benefits and may be subject to the same limitations that apply to other covered health conditions.

[s. 632.895 (4)]

MUST A DISABILITY (ACCIDENT & HEALTH) INSURANCE POLICY PROVIDE COVERAGE FOR NEWBORN INFANTS?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, must provide coverage for a newly-born child of the insured from the moment of birth. The newborn has the same coverage as the policy provides for any children covered or eligible for coverage under the policy, except that waiting periods do not apply. If a person who is pregnant or whose spouse is pregnant makes application for a policy providing hospital and/or medical expense benefits, the insurer may not issue a policy that excludes or limits benefits for the expected child. The policy must be issued without the exclusion or limitation. Coverage for newly-born children must treat congenital defects and birth abnormalities as an injury or sickness under the policy. The disability (accident & health) policy must cover functional repair or restoration of any body part when necessary to achieve normal body functioning. Coverage is not required for “cosmetic” surgery performed only to improve appearance.

[s. 632.895 (5), s. Ins 3.38]

WHAT IF AN ADDITIONAL PREMIUM IS REQUIRED TO PROVIDE COVERAGE FOR A NEWBORN INFANT?

If the payment of a specific premium or subscription fee is required to provide coverage for a child, the policy may require that notification of a child’s birth and payment of the required premiums or fees be furnished to the insurer within 60 days after the date of birth. The insurer may refuse to continue coverage beyond the 60-day period if such notification is not received, unless within one year after the birth of the child the insured makes all past due payments with interest at the rate of 5 1/2% per annum.

If the payment of a specific premium or subscription fee is not required to provide coverage for a child, the policy or contract may request notification of the birth of a child but may not deny or refuse to continue coverage if such notification is not furnished.

[s. 632.895 (5)]

MUST A DISABILITY (ACCIDENT & HEALTH) INSURANCE POLICY PROVIDE COVERAGE FOR ADOPTED CHILDREN?

Yes. Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, that provides coverage for dependent children of the insured must provide coverage for children who are adopted or placed for adoption. This includes health maintenance organizations, preferred provider plans, and limited service health organizations.

[ss. 609.75, 631.07 (3) (a) 3. m., 632.896]

MUST GRANDCHILDREN BE COVERED?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, that provides coverage for a dependent child of the insured must provide the same coverage for children of the dependent child until the dependent child is age 18.

[s. 632.895 (5m)]

WHAT BENEFITS MUST BE PROVIDED FOR TREATMENT OF DIABETES?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, that provides coverage of expenses incurred for treatment of diabetes must provide coverage for expenses incurred by the installation and use of an insulin infusion pump and provide coverage for all other equipment and supplies, including insulin or any other prescription medication, used in the treatment of diabetes. Policies must also provide coverage of diabetic self-management education programs.

Coverage may be subject to the same deductible and coinsurance as other covered expenses. Insulin infusion pump coverage may be limited to the purchase of one pump per year and the insurer may require the insured to use a pump for 30 days before purchase.

Prescription medication coverage for the treatment of diabetes is not available under a Medicare supplement policy or Medicare replacement policy issued after January 1, 2006, because the coverage is available under Medicare Part D.

[s. 632.895 (6)]

MUST MATERNITY BENEFITS BE PROVIDED FOR DEPENDENT CHILDREN?

Every group disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, that provides maternity coverage must provide maternity coverage for all persons covered under the policy. If a group policy provides maternity coverage for the insured or insured's spouse, the maternity coverage must also be provided for any dependent children covered under the policy.

[s. 632.895 (7)]

WHAT BENEFITS MUST BE PROVIDED FOR MAMMOGRAMS?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, accident only, specified disease, Medicare supplement, Medicare replacement, or long-term care policy that provides coverage for a woman age 45 or older, must provide coverage for periodic mammographies. Coverage is required regardless of whether the woman shows any symptoms of breast cancer. The policy may not apply exclusions or limitations that do not apply to other radiological examinations covered under the policy.

[ss. 609.80, 632.895 (8)]

WHAT BENEFITS MUST BE PROVIDED FOR LEAD POISONING SCREENING?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, accident only policy, specified disease, Medicare supplement, Medicare replacement or long-term care policy, must provide coverage for blood lead tests for children under 6 years of age, which are conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the department of health and social services.

[s. 632.895 (10)]

WHAT BENEFITS MUST BE PROVIDED FOR TEMPOROMANDIBULAR JOINT DISORDERS?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, accident only, dental, Medicare supplement and Medicare replacement policy, but including self-funded municipalities or self-funded school district plans, that provides coverage of any diagnostic or surgical procedure involving a bone, joint, muscle or tissue must provide coverage for diagnostic procedures and medically necessary surgical or non-surgical treatment (including prescribed intraoral splint therapy devices) for the correction of temporomandibular (TMJ) disorders.

[s.632.895 (11)]

WHAT BENEFITS MUST BE PROVIDED FOR HOSPITAL AND AMBULATORY SURGERY CENTER CHARGES AND ANESTHETICS FOR DENTAL CARE?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, accident only or dental policy, but including self-funded municipalities or self-funded school district plans,

must cover hospital or ambulatory surgery center charges incurred and anesthetics provided in conjunction with dental care if any of the following applies:

1. The individual is a child under the age of 5
2. The individual has a chronic disability that meets all the conditions in s. 230.04 (9r) (a) 2. a., b., and c., Wis. Stat.
3. The individual has a medical condition that requires hospitalization or general anesthesia for dental care.

[s. 632.895 (12)]

WHAT BENEFITS MUST BE PROVIDED FOR BREAST RECONSTRUCTION?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, but self-funded municipalities or self-funded school district plans, that provides coverage for a mastectomy must provide coverage of breast reconstruction of the affected tissue incident to a mastectomy.

[s. 632.895 (13)]

WHAT BENEFITS MUST BE PROVIDED FOR IMMUNIZATIONS FOR CHILDREN?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, accident only, specified disease, hospital/surgical, Medicare supplement, Medicare replacement, or long-term care policy, but including self-funded municipalities or self-funded school district plans, that provides coverage for a dependent of an insured must provide coverage of appropriate and necessary immunizations, from birth to the age of 6 years, for a dependent who is a child of the insured. The coverage may not be subject to any deductibles, copayments, or coinsurance under the policy or plan.

[s. 632.895 (14)]

WHAT BENEFITS MUST BE PROVIDED FOR TREATMENT FOR AUTISM SPECTRUM DISORDERS?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, accident only, specified disease, Medicare supplement, Medicare replacement, or long-term care policy, but including self-funded municipalities or self-funded school district plans, must provide coverage for an insured of treatment for the mental health condition of autism spectrum disorder if the treatment is prescribed by a physician and provided by a professional qualified to provide intensive-level services or nonintensive-level services.

[s. 632.895 (12m)]

WHAT BENEFITS MUST BE PROVIDED FOR A STUDENT ON MEDICAL LEAVE?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, but including self-funded municipalities or self-funded school district plans, that provides coverage for a person as a dependent of the insured because the person is a full-time student must continue to provide dependent coverage for the person if, due to a medically necessary leave of absence, he or she ceases to be a full-time student. The policy continuation is limited to one year from the date the person's coverage continuation began and the person has not returned to school full time. This statute is also known as Michele's Law.

[s. 632.895 (15)]

WHAT BENEFITS MUST BE PROVIDED FOR HEARING AIDS, COCHLEAR IMPLANTS, AND RELATED TREATMENT FOR INFANTS AND CHILDREN?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, accident only, specified disease, limited-scope dental or vision, Medicare supplement, Medicare replacement, or long-term care policy, but including self-funded municipalities or self-funded school district plans, must provide coverage of the cost of hearing aids and cochlear implants that are prescribed for a child covered under the policy who is under 18 years of age and who is certified as deaf or hearing impaired by a physician or by an audiologist.

[s. 632.895 (16)]

WHAT BENEFITS MUST BE PROVIDED FOR COLORECTAL CANCER SCREENING?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, but including self-funded municipalities or self-funded school district plans, that provides coverage of any diagnostic or surgical procedures must provide coverage of colorectal cancer examinations and laboratory tests for insureds and enrollees who are 50 years of age or older and for insureds or enrollees under age 50 and at high risk for colorectal cancer.

[s. 632.895 (16m)]

WHAT BENEFITS MUST BE PROVIDED FOR CONTRACEPTIVES AND SERVICES?

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, accident only policy, specified disease, limited-scope dental or vision, Medicare supplement, Medicare replacement, or long-term care policy, but including self-funded municipalities or self-funded school district plans, that provides coverage of outpatient health care services, preventive treatments and services, or prescription drugs and devices must provide coverage of all of the following:

- Contraceptives prescribed by a health provider.
- Outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive, if covered for any other drug benefits under the policy or plan.

[s. 632.895 (17)]

WHAT BENEFITS MUST BE PROVIDED FOR CANCER CLINICAL TRIALS?

No policy, plan or contract may exclude coverage for the cost of any routine patient care that is administered to an insured in an approved cancer clinical trial satisfying the specific criteria described in the regulation. The policy, plan, or contract is not required to reimburse services by a nonparticipating provider at the same rate as a participating provider.

[s. 632.87 (6)]

C. Marketing Methods and Practices

WHAT STANDARDS APPLY TO ADVERTISEMENTS FOR DISABILITY (ACCIDENT & HEALTH) INSURANCE?

Prospective buyers of disability (accident & health) insurance must be provided with clear and unambiguous statements, explanations, advertisements, and written proposals concerning policies offered to them.

Section Ins 3.27, Wis. Adm. Code, outlines the minimum standards and guidelines for the advertising and selling of disability (accident & health) insurance policies.

Advertisements and representations must be truthful, and not misleading, and must accurately describe the policy to which they apply.

In addition, the content, form, and method of dissemination of all advertisements, regardless by whom designed, created, written, printed, or used, are the responsibility of the insurer whose policy is advertised. Insurers must require agents to submit all proposed disability (accident & health) advertising to them prior to use.

[s. 628.34, s. Ins 3.27]

WHAT IS AN ADVERTISEMENT?

An advertisement means printed as well as oral representations. This includes:

- Printed and published material, audio visual material, and descriptive material and literature of an insurer used in the media, including the internet and web pages, except for advertisements prepared for the sole purpose of obtaining employees, intermediaries, or agencies;
- Descriptive literature and sales aids of all kinds issued by an insurer or intermediary for presentation to members of the public;
- Prepared sales talks, presentations of material used by intermediaries and representations made by agents in accordance with these talks and presentations, except for materials to be used solely by the insurer for the training and education of its employees or intermediaries.

[s. 628.34, s. Ins 3.27 (5) (a)]

WHO IS RESPONSIBLE FOR DETERMINING THE "SUITABILITY" OF A POLICY FOR A PROSPECTIVE BUYER?

Before an intermediary or insurer can advise a prospective buyer to buy an individual policy, the agent or insurer must have reasonable grounds to believe that the recommendation is not unsuitable for the applicant.

The intermediary or insurer must ask such questions as are necessary to determine that the purchase of such insurance is not unsuitable for the prospective buyer.

This rule does not apply to an individual policy issued on a group basis.

[s. 628.34, s. Ins 3.27 (7)]

MUST AN ADVERTISEMENT IDENTIFY THE INSURANCE COMPANY?

The identity of the insurer must be made clear in all of its advertisements. An advertisement may not use a trade name, insurance group designation, name of the parent company of the insurer, name of a government agency or program, name of any other organization, service mark, slogan, or symbol or any device that has the capacity and tendency to mislead or deceive as to the identity of the insurer.

An advertisement may not use any combination of words, symbols, or materials that, by their content, phraseology, shape, color, nature, or other characteristics, is so similar to any materials used by federal, state, or local government agencies that it tends to confuse or mislead prospective buyers into believing that the solicitation is in some manner connected with the government agency.

[s. 628.34, s. Ins 3.27 (12)]

WHAT REQUIREMENTS MUST ADVERTISEMENTS MEET REGARDING TESTIMONIALS, ENDORSEMENTS, OR COMMENDATIONS BY THIRD PARTIES?

A testimonial means any statement made by a policyholder, or certificate holder that promotes the insurer and its policy by describing such person's benefits, favorable treatment, or other experience under the policy.

An endorsement means any statement promoting the insurer and its policy made by an individual, group of individuals, society, association, or other organization that makes no reference to the endorser's experience under the policy.

The testimonial or endorsement must be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. An advertisement may not state or imply that an insurer or a policy has been approved or endorsed by an individual, group of individuals, society, association, or other organization, unless it is a fact. An advertisement may not state or imply that a government publication has commended or recommended the insurer or its policy.

An advertisement may not contain a testimonial, endorsement, or other statement concerning the insurer, its policies, or activities by any person who receives direct or indirect compensation from the insurer in connection with the testimonial, endorsement, or statement, unless the advertisement discloses that the person giving the testimonial or endorsement is being paid. The rules of this paragraph do not apply if the person making the testimonial, endorsement, or statement holds a Wisconsin insurance intermediary license, or if the person is a radio or television announcer that is employed or compensated on a salaried or union wage scale basis.

[s. 628.34, ss. Ins 3.27 (5), (13)]

ARE ADVERTISEMENTS ALLOWED TO CONTAIN DISPARAGING COMPARISONS AND STATEMENTS?

An advertisement may not directly or indirectly make unfair or incomplete comparisons of policies or benefits. An advertisement may not falsely or unfairly disparage, discredit, or criticize competitors, their policies, services, or business methods or competing marketing methods.

[s. 628.34, s. Ins 3.27 (23)]

WHAT IS THE METHOD OF DISCLOSURE OF REQUIRED INFORMATION?

All information required to be disclosed to the prospective buyer by s. Ins 3.27, Wis. Adm. Code, must be set out clearly, conspicuously, and in close proximity to the statements to which such information relates. Required information can also be set out under appropriate captions of such prominence that it is readily noticed and not minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

[s. 628.34, s. Ins 3.27 (24)]

WHAT OTHER STANDARDS MUST BE MET WHEN AN ADVERTISEMENT CONTAINS STATEMENTS ABOUT AN INSURER?

An advertisement may not contain statements that are untrue or are by implication misleading with respect to the insurer's assets, corporate structure, financial standing, age, experience, or relative position in the insurance business.

[s. 628.34, s. Ins 3.27 (22)]

D. Requirements for Group Health Policies

WHAT ARE THE CONTINUATION/CONVERSION PRIVILEGES OF INSUREDS UNDER GROUP AND INDIVIDUAL HEALTH INSURANCE POLICIES?

Wisconsin has a continuation/conversion law for both group and individual health insurance policies.

The major provisions are:

- Insurers must permit people who have been insured for at least three months under a group contract to continue group coverage or convert to an individual contract if the group coverage ends because of divorce, annulment, death or any other reason except discharge for misconduct.
- The rate for continued group coverage cannot be more than the group rate (including the employer's contribution).
- Employers must continue to accept premiums from these insureds.
- After 18 months, insurers can require those who elect continuation to switch to an individual conversion policy which has been filed with the Office of the Commissioner of Insurance.
- Insurers or group policyholders must notify insureds of their continuation/conversion options when their group coverage terminates.
- Individual policies under which coverage for dependent spouses and children is terminated after a divorce or annulment must provide a conversion option.
- Wisconsin continuation/conversion law also applies to group and individual long-term care insurance policies.

There is also a federal law relating to continuation. This law (COBRA) applies to most employers with 20 or more employees. There are some differences between the state and federal law. The federal Department of Labor enforces COBRA law.

[s. 632.897, ss. Ins 3.41, 3.42, 3.43, 3.44, 3.45, 3.455]

WHAT IS A SMALL EMPLOYER?

A small employer means an individual, firm, corporation, partnership, limited liability company, or association that is actively engaged in a business enterprise in Wisconsin, including a farm business, and that employs an average of at least 2 but not more than 50 employees on business days during the preceding calendar year, or that is reasonably expected to employ at least 2 but not more than 50 employees on business days during the current calendar year if the employer was not in existence during the preceding calendar year and employs at least 2 employees on the first day of the plan year. All persons treated as a single employer under the Internal Revenue Code of 1986 must be treated as one employer.

[s. 635.02 (7)]

ARE THERE PROHIBITED COVERAGE PRACTICES RELATING TO EMPLOYER GROUP HEALTH BENEFIT PLANS?

Yes. An insurer that offers a group health benefit plan to an employer must offer coverage to all of the employer's eligible employees and their dependents. Insurers may not offer coverage to only certain individuals in the group or to only part of the group, except for an eligible employee who has not yet satisfied a waiting period, if any.

An eligible employee means an employee who works on a permanent basis and has a normal work week of 30 or more hours. The term includes a sole proprietor, a business owner, including the owner of a farm business, a partner of a partnership and a member of a limited liability company if such a person is included as an employee under a health benefit plan of an employer. The term does not include an employee who works on a temporary or substitute basis.

An insurer that provides coverage under a group health benefit plan must provide coverage to eligible employees and their dependents who become eligible for coverage after the commencement of the employer's coverage, regardless of their health conditions or claims experience, if the employee has satisfied any applicable waiting period and the employer agrees to pay the premium required for coverage of the employee under the plan.

Rules for eligibility to enroll under a group health benefit plan include rules defining any applicable waiting periods for enrollment.

[ss. 632.746 (10), 632.747, 632.748]

ARE THERE SPECIAL REGULATIONS REGARDING THE TERMINATION OR NONRENEWAL OF EMPLOYER GROUP HEALTH BENEFIT PLANS?

Yes. Except as otherwise permitted below, an insurer that offers a group health benefit plan must renew such coverage or continue such coverage in force at the option of the employer and, if applicable, plan sponsor. An insurer may modify a group health benefit plan issued in the large group market at the time of renewal.

An insurer may nonrenew or discontinue a group health benefit plan only for the following reasons:

- Nonpayment of premium.
- Fraud.
- Failure to meet minimum participation or employer contribution requirements.
- The insurer ceases to offer coverage in the market in which the group health benefit plan is included.
- In the case of network plans, there is no longer an enrollee under the plan who resides, lives or works in the service area.
- In the case where coverage is provided through a bona fide association, the employer ceases to be a member of the association on which the coverage is based. Coverage must be terminated uniformly without regard to any health status-related factor of any covered individual.

An insurer may discontinue offering a particular type of group health benefit plan in either the small or large group market if all the following apply:

1. The insurer provides notice of the discontinuance to each employer and plan sponsor and to the participants and beneficiaries who have such coverage at least 90 days before the date coverage will be discontinued.
2. The insurer offers to each employer or plan sponsor the option to purchase from among all of the other group health benefit plans that the insurer offers in the market in which the discontinued plan is included. However, in the large group market, the insurer must offer each employer or plan sponsor the option to purchase one other group health benefit plan that the insurer offers in the large group market.
3. The insurer must act uniformly without regard to any health status-related factor of any covered participants or beneficiaries who may become eligible for coverage.

An insurer may discontinue offering in this state all group health benefit plans in the large or small group market, or in both, only if all the following apply:

1. The insurer provides notice of the discontinuance to the Commissioner, to each employer and plan sponsor, and to the participants and beneficiaries who have such coverage in this state at least 180 days before the date coverage will be discontinued.
 2. All group health benefit plans issued or delivered for issuance in this state in the affected market are discontinued and coverage under such plans is not renewed.
 3. The insurer does not issue or deliver for issuance in this state any group health benefit plan in the affected market before 5 years after the day on which the last group health benefit plan is discontinued.
- [s. 632.749]

ARE THERE SPECIAL REGULATIONS REGARDING THE TERMINATION OR NONRENEWAL OF INDIVIDUAL HEALTH BENEFIT PLANS?

Yes. Except as otherwise permitted below, an insurer that provides individual health benefit plan coverage must renew such coverage or continue such coverage in force at the option of the insured individual and, if applicable, the association through which the individual has coverage. An insurer may modify an individual health benefit plan coverage policy form at the time of renewal, as long as the modification is consistent with state law and effective on a uniform basis among all individuals with coverage under that policy form.

An insurer may nonrenew or discontinue the individual health benefit plan coverage of an individual only for the following reasons:

- Nonpayment of premium.
- Fraud.
- The insurer ceases to offer individual health benefit plan coverage.
- In the case of network plans, the individual no longer resides, lives or works in service area. Coverage must be terminated uniformly without regard to any health status-related factor of any covered individual.
- In the case where coverage is provided through a bona fide association, the individual ceases to be a member of the association on which the coverage is based. Coverage must be terminated uniformly without regard to any health status-related factor of any covered individual.
- The individual is eligible for Medicare and the Commissioner by rule permits coverage to be terminated.

An insurer may discontinue offering a particular type of individual health benefit plan coverage in this state if all the following apply:

1. The insurer provides notice of the discontinuance to each individual for whom the insurer provides coverage of this type and, if applicable, the association through which the individual has coverage at least 90 days before the date coverage will be discontinued.
2. The insurer offers to each individual for whom the insurer provides coverage of this type and, if applicable, the association through which the individual has coverage the option to purchase any other type of individual health insurance coverage that the insurer offers for individuals.
3. The insurer must act uniformly without regard to any health status-related factor of individuals who may become eligible for coverage.

An insurer may discontinue offering in this state individual health benefit plan coverage only if all the following apply:

1. The insurer provides notice of the discontinuance to the Commissioner and to each individual for whom the insurer provides individual health benefit plan coverage in this state and, if applicable, to the association through which the individual has coverage at least 180 days before the date coverage will be discontinued.
2. All individual health benefit plan coverage issued or delivered for issuance in this state is discontinued and coverage under such plans is not renewed.
3. The insurer does not issue or deliver for issuance in this state any individual health benefit plan coverage before 5 years after the day on which the last individual health benefit plan coverage is discontinued.

An insurer is not required to renew individual health benefit plan coverage that is marketed and designed to provide short-term coverage as a bridge between coverages.

[s. 632.7495]

ARE THERE SPECIAL REGULATIONS FOR MANAGED CARE PLANS?

Yes. A managed care plan is defined as any health benefit plan that requires or creates incentives for an enrollee to use providers that are owned, managed, or under contract with the insurer offering the health benefit plan.

Wisconsin statutes define three different types of managed care plans. They are health maintenance organizations, preferred provider plans, and limited service health organizations.

A “defined network plan” (managed care plan) is a health benefit plan that requires an enrollee or creates incentives for an enrollee to use providers that are managed, owned, under contract with or employed by the insurer.

A “health maintenance organization” is a health care plan that makes available to enrolled participants, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers selected by the organization.

A “limited service health organization” is a health care plan that makes available to enrolled participants, in consideration for predetermined periodic fixed payments, a limited range of health care services performed by providers selected by the organization.

A “preferred provider plan” (PPP) is a health care plan that pays a specific level of benefits if plan providers are used and a lesser amount if non-plan providers are utilized. A PPP offers financial incentives to use network providers through the use of coinsurance and deductible amounts.

Except for an employer with fewer than 25 full-time employees, an employer that offers any of its employees a health maintenance organization or a comprehensive preferred provider plan must also offer employees a standard plan. Employers must give employees an annual opportunity to enroll in the plans provided. Employers must also give employees adequate notice of the opportunity to enroll in the health care plans and complete and understandable information concerning the differences between the plans offered.

[ch. 609, ch. Ins 9]

E. Medicare Supplement

WHAT ABOUT INSURANCE PLANS THAT “SUPPLEMENT” MEDICARE?

Medicare supplemental insurance, also known as Medigap, is designed to provide coverage for some of the “gaps” left by Medicare. Because Medicare may not cover all of the services needed and because Medicare requires recipients to pay deductibles, coinsurance, and copayments, many people purchase Medicare supplement policies to help pay for some of those extra services and costs. Medicare supplement policies are offered by private health insurance issuers. Medicare replacement policies also supplement Medicare benefits but are contracts between the federal government and qualified health maintenance organizations to provide health care benefits to persons eligible for Medicare.

Medicare select, which may be offered by insurance companies and health maintenance organizations (HMOs), is the same as standard Medicare supplement insurance in nearly all respects. The only difference between Medicare select and standard Medicare supplement insurance is that Medicare select policies will only pay full supplemental benefits if covered services are obtained through plan providers selected by the insurance company or HMO.

[ss. 628.34, 632.84, ss. Ins 3.27, 3.39]

F. Short-term Medical Policies

WHAT ARE SHORT-TERM MEDICAL POLICIES?

Short-term medical insurance is designed for healthy individuals and families who do not need coverage for preexisting conditions. Short-term medical policies are temporary solutions that can provide a low-cost safety net in case of illness or injury that might develop during the coverage period.

Most short-term policies limit the amount of time that the insured can keep the policy to 12 months or less. Short-term health insurance is typically bought in one-month increments that make it convenient to drop at the end of any month. Short-term medical policies are not renewable. The insured may apply for one additional policy. This second policy is not a continuation of the first. Insurers can refuse to issue a second policy if the insured filed any claims under the previous short-term policy. Others might offer the insured another policy, but they can treat any injuries or illnesses that occurred during the previous short-term policy as preexisting conditions and will not cover treatment related to such conditions.

Most insurers only sell short-term health policies to people under the age of 65. Each short-term health plan has its own application that contains a number of questions. Additionally, applicants must meet acceptance guidelines, usually including acceptable height and weight.

[s. 632.7495 (4)]