

**ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE REPEALING,
AMENDING, AND CREATING A RULE**

To repeal Ins 18.18 (5);

To amend Ins 18.01 (4); 18.10 (4) (d); 18.11 (2) (a) (intro.), 1., 2., 4., and 5.; 18.12 (1) (b) 1. and 2., (e) 7., (4) and (5); 18.12 (4) and (5); 18.16 (2) (e) and (i), 18.18 (6); and

To create Ins 18.01 (2m) and (10); 18.10 (4e) and (4m); 18.11 (2) (a) 7., (b), (3) (bm) and (4); 18.12 (1) (e) 8., (1) (d); 18.12 (6m); 18.13; 18.16 (2) (em), Wis. Adm. Code,

Relating to independent review procedures.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. Statutes interpreted:

ss. 600.01, 628.34 (12), and 632.835, Stats.

2. Statutory authority:

ss. 600.01 (2), 601.41 (3), 601.42 (2), 628.34 (12), and (632.835 (5) and (8), Stats.

3. Explanation of OCI's authority to promulgate the proposed rule under these statutes:

2009 Wisconsin Act 28 amended the existing independent review definitions and procedures and incorporated two new triggering events for independent review rights and reporting requirements. Newly created provisions include new definitions of coverage denial determinations, preexisting condition exclusion denial and rescission determinations. The Act also created independent review eligibility for preexisting condition exclusion denial determinations and rescissions. The commissioner must render a determination that at least one independent review organization has completed the certification process and is able to effectively provide independent reviews for coverage denial determinations.

4. Related statutes or rules:

Chapter INS 18 subch. I and II, Wis. Adm. Code.

5. The plain language analysis and summary of the proposed rule:

The proposed rule implements 2009 Wis. Act 28 that expanded existing independent review rights for Wisconsin insureds. The proposed rule amends the existing rule to include the newly created statutory terms of coverage denial determination and preexisting condition exclusion denial determination. As with the amended statute, the rule is modified by replacing the term "adverse determination and experimental treatment determination" with the more inclusive term "coverage denial determination" throughout ch. Ins 18, subch. III.

The commissioner is directed in s. 632.853 (8) (b), Stats., to determine that at least one independent review organization has been certified that can effectively provide independent review of preexisting condition exclusion denial determinations and rescissions. In order to make the determination, the proposed rule clarifies what

types of denials are eligible under preexisting condition exclusion denial determination reviews and the type of expertise independent review organizations need to render determinations. The proposed rule requires independent review organizations to utilize the expertise of state licensed lawyers and certified actuaries when appropriate. The lawyers and actuaries must be current in their credentialing or licensure and can assist the independent review organization as an advisor or participant on the review panel at the discretion of the organization.

The proposed rule also modifies a portion of ch. Ins 18, subch. I and II to reflect that insureds not only have a right to independent review but also the grievance process established by insurers. This is a new right for persons that have had a policy rescinded or coverage denied as preexisting. The modifications clarify what is not subject to a grievance or independent review, specifically that administrative issues are not eligible for independent review. The proposed rule also clarifies that when an insurer and insured dispute whether an issue is eligible for independent review, that dispute is eligible for review.

Additionally, the proposed rule includes amended reference that depending upon the type of issue under independent review that the determination may be binding on the insurer and insured. The proposed rule updates the compendium that independent review organizations may use to reflect name or source changes and creates legal resources as a new source of information that can be utilized by the independent review organizations.

Finally, the proposed rule parallels implementation of the new preexisting condition denial and rescission determinations that was available when independent review was first implemented. For eligible preexisting condition coverage denial and rescission determinations that occur after January 1, 2010 the date of the notice from the commissioner that he has certified the availability of an independent review organization to review preexisting condition and rescission issues, insureds will have 4 months to request an independent review. Once the commissioner has published notice that he has certified the availability of an independent review organization to review preexisting condition and rescission issues, insureds will have 4 months to file requests for independent review from the date of the preexisting condition exclusion denial or rescission determination by the insurer or from the date of receipt of notice of the grievance panel decision, whichever is later.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 created an external review right for issued individual and group health policies for adverse and experimental treatment determinations to follow NAIC model. Further the PPACA restricts insurers from applying preexisting conditions limitations to insureds and limits rescissions to situations of fraud or intentional misrepresentation. These changes are first effective September 23, 2010.

7. Comparison of similar rules in adjacent states as found by OCI:

Illinois: In 2000 Illinois enacted the managed care reform and patients right act 215 ILCS 134, initiating external review for insured enrolled in health maintenance organizations a right to external review of medical necessity determinations. On January 5, 2010, Illinois enacted the health carrier external review act that broadens the right to external review to all Illinois residents enrolled in health insurance plans under 215 ILCS 180. The review is limited to adverse determinations and does not include review of preexisting condition denials or rescissions.

Iowa: Effective January 1, 2000, Iowa enacted a right to external review arising from medical necessity determinations at Iowa Code section 514J. On January 1, 2009, Iowa extended external review to long-term care insurance benefit trigger determinations. Iowa Code section 514G.110. Iowa law does not include external review for preexisting condition denials or rescission determinations.

Michigan: Effective October 1, 2000, Michigan offers external review for adverse determinations based upon medical necessity that are unresolved internally by the plan. 2000 PA 251, MCL 550.1911. An adverse determination is a decision by a health carrier that denies a health care service, reduces coverage for a health care service or terminates coverage for a health care service. Failure to make a timely decision in response to a request for a determination is also considered an adverse determination.

Minnesota: Effective 2000 Minnesota enacted law that provider external review relating to medical necessity determinations from managed care plans and indemnity carriers. Minn. Stat. 72A.327. The law does not include external review for preexisting condition denials or rescission determinations and assumes denials arise from utilization review only.

8. A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:

The commissioner created a working group to assist in the development of the proposed rule. The working group included representatives from the insurance industry, independent review organizations, consumer advocates and the public and staffed by the office including the managed care specialist whose duties include the oversight of independent review organizations. Meetings were held monthly between September and December, 2009. The working group considered information regarding the number of complaints the office receives annually relating to preexisting condition exclusions and rescissions when developing its recommendation to the commissioner. In addition, the consumer representatives provided current case law and issues seen from constituents.

The working group unanimously made its recommendations to the commissioner and those recommendations are reflected in the proposed rule.

9. Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:

The office reviewed the number and type of complaints relating to preexisting condition exclusion denials and rescissions. On average, there are approximately 273 cancellations and rescissions reported for 2009 in the state. The independent review organizations are certified by the commissioner's designee to conduct independent reviews in the state and several are small businesses, however the additional cost, if any, will be primarily borne by large insurers not the independent review organizations. The proposed rule places few additional requirements on the independent review organizations and in clarifying what is and is not eligible for reviews, the costs incurred will be limited. Finally, it was noted during the rule development process at the working group that most independent review organizations already have access to lawyers as needed so there is no additional cost associated with the proposed requirement.

10. See the attached Private Sector Fiscal Analysis.

11. A description of the Effect on Small Business:

This rule will have little or no effect on small businesses.

12. Agency contact person:

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at: <http://oci.wi.gov/ocirules.htm>

or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: inger.williams@wisconsin.gov
Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on the 14th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

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Web site: <http://oci.wi.gov/ocirules.htm>

SECTION 1. Ins 18.01 (2m) and (10) are created to read:

Ins 18.01 (2m) “Coverage denial determination” has the meaning as defined in s. 632.835 (1) (ag), Stats., and includes, for individual insurance products, a policy reformation or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant’s age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

(10) "Rescission" or "reformation" of a policy means a determination by an insurer offering health benefit plan, subject to s. 628.34 (3), Stats., to withdraw the coverage back to the initial date of coverage, modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by the insurer to all similar individual policy forms is not a rescission or reformation of a policy.

SECTION 2. Ins 18.01 (4) is amended to read:

(4) "Grievance" means any dissatisfaction with ~~the provision of services or claims practices~~ of 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 any of the following:

(a) Provision of services.

(b) Determination to reform or rescind a policy.

(c) Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders.

(d) Claims practices.

SECTION 3. Ins 18.05 is amended to read:

Ins 18.05 Expedited grievance procedure. Section Ins 18.03 (2) to (4) do not apply to expedited grievances. For these situations, an insurer offering a health benefit plan shall develop a separate expedited grievance procedure. An expedited grievance shall be resolved as expeditiously as the insured's health condition requires but not more than 72 hours after receipt of the grievance. An insurer offering a health benefit plan, upon written request, shall mail or electronically mail a copy of the insured's complete policy to the insured or the insured's authorized representative as expeditiously as the grievance is handled.

SECTION 4. Ins 18.10 (4) (d) is amended to read:

Ins 18.10 (4) (d) Any of the following standard reference compendia most current edition in publication at the time of the dispute:

1. The American Hospital Formulary Service – Drug Information.
2. ~~The American Medical Association of Drug Evaluation~~ Center for Drug Evaluation and Research History.
3. ~~The American Dental Association Accepted Dental Therapeutics~~ ADA/PDR Guide to Dental Therapeutics, current edition.
4. The United States ~~Pharmacopoeia—Drug Information~~ Pharmacopoeia –National Formulary.

SECTION 5. Ins 18.10 (4e) and (4m) are created to read:

Ins 18.10 (4e) “Preexisting condition exclusion denial determination” has the meaning as defined in s. 632.835 (1) (cm), Stats.

(4m) “Legal basis” means information from any of the following sources:

- (a) The most current version of The American Journal of Jurisprudence.
- (b) United States 7th Judicial Circuit Court decisions.
- (c) Wisconsin statutory and common law.
- (c) The terms of the insurance contract applicable for the period of coverage in dispute.

SECTION 6. Ins 18.11 (2) (a) (intro.), 1., 2., 4., and 5., are amended to read:

Ins 18.11 (2) NOTIFICATION OF RIGHT TO INDEPENDENT REVIEW. In addition to the requirements of s. 632.835 (2) (b) or (2) (bg), Stats., and s. Ins 18.03, each time an insurer offering a health benefit plan makes ~~an adverse determination or an experimental treatment a coverage denial~~ determination the insurer shall provide all of the following in the notice to the insureds:

(a) A notice to an insured of the right to request an independent review. The notice shall comply with s. 632.835 (2) (b) or (2) (bg), Stats., and when required, to be accompanied by the informational brochure developed by the office, or in a form substantially similar, ~~describing~~describe the independent review process. The notice shall be sent when the insurer

offering a health benefit plan makes ~~an adverse determination or experimental treatment a~~ coverage denial determination. In addition, the notice shall contain all of the following information:

1. ~~In accordance with s. 632.835 (9), Stats., for adverse determinations or experimental treatment determinations occurring on or after December 1, 2000, but prior to the date stated in the notice published by the commissioner in the Wisconsin Administrative Register under s. 632.835 (8), Stats., the notice to an insured shall state that the insured, or the insured's authorized representative, must request the independent review within 4 months from the date stated in the notice published by the commissioner in the Wisconsin Administrative Register under s. 632.835 (8), Stats.~~

2. ~~For adverse determinations or experimental treatment~~ coverage denial determinations occurring subsequent to the date stated in the notice published by the commissioner in the Wisconsin Administrative Register under s. 632.835 (8), Stats., after June 15, 2002, the notice to an insured shall, in accordance with s. 632.835 (2) (c), Stats., state that the insured, or the insured's authorized representative, must request independent review within 4 months from the date of the ~~adverse determination or experimental treatment~~ coverage denial determination by the insurer or from the date of receipt of notice of the grievance panel decision, whichever is later.

4. The notice shall state that the insured's, or the insured's authorized representative's, request for an independent review must be made in writing, and contain the name of the selected independent review organization ~~and be accompanied with the \$25 fee payable to the independent review organization~~. The notice shall also state that the insured's, or the insured's authorized representative, written request be submitted to the insurer and must contain the address and name of the person or position to whom the request is to be sent. ~~The notice shall state that if the insured or insured's authorized representative prevails in the review, either in whole or in part, the \$25 fee paid to the independent review organization will be refunded to the insured by the insurer.~~

5. The notice shall include a statement that references s. 632.835 (3) (f), Stats., informing the insured that once the independent review organization makes a determination, the determination is may be binding upon the insurer and insured. For preexisting condition exclusion and rescission denial determinations, the notice shall indicate that the independent review organization determination is not binding on the insured.

SECTION 7. Ins 18.11 (2) (a) 7., and (b) are created to read:

Ins 18.11 (2) (a) 7. The notice shall include a brief summary statement regarding Health Insurance Risk Sharing Plan eligibility as required in s. 632.785, Stats., when the coverage denial determination involved a policy rescission.

(2) (b). 1. For preexisting condition exclusion denial and rescission determinations that occur on or after January 1, 2010, but prior to the date stated in the notice published by the commissioner in the Wisconsin Administrative Register under s. 632.835 (8) (b), Stats., the notice to an insured shall state that the insured, or the insured's authorized representative, must request the independent review within 4 months from the date stated in the notice published by the commissioner in the Wisconsin Administrative Register under s. 632.835 (8) (b), Stats.

2. For preexisting condition exclusion denial and rescission determinations occurring subsequent to the date stated in the notice published by the commissioner in the Wisconsin Administrative Register under s. 632.835 (8) (b), Stats., the notice to an insured shall comply with par. (2) (a), state that the insured, or the insured's authorized representative, must request the independent review within 4 months from the date of the preexisting condition exclusion denial or rescission determination by the insurer or from the date of receipt of notice of the grievance panel decision, whichever is later.

SECTION 8. Ins 18.11 (3) (bm) and (4) are created to read:

Ins 18.11 (3) (bm) The insurer offering a health benefit plan shall provide, upon written request from the insurer or the insured's authorized representative, a complete copy of the insured's policy. The insurer offering a health benefit plan shall respond to the written request within 3 business days of the request by mailing or electronically mailing the copy to the insured or the insured's authorized representative in the format requested.

Ins 18.11 (4) Disputes. (a) A dispute between an insured and an insurer regarding eligibility for independent review shall be considered a coverage denial determination and the insured may seek independent review of the determination in accordance with this section.

(b) Disputes that are related to administrative matters, including enrollment eligibility, not related to treatment or services are not eligible for independent review determinations.

SECTION 9. Ins 18.12 (1) (b) 1. and 2., (e) 7., (4), and (5), are amended to read:

Ins 18.12 (1) (b) 1. Whether a conflict of interest exists. If a conflict exists, the independent review organization shall provide a written notification to the insurer, the commissioner and the insured, or the insured's authorized representative, within 3 business days stating that a conflict exists and declining to take the review, indicating that a different independent review organization will need to be selected by the insured, or the insured's authorized representative.

2. The type of case for which review is sought. The independent review organization shall determine if the case relates to ~~an adverse determination, experimental treatment determination~~ a coverage denial determination or an administrative issue. If the independent review organization determines that the review is not related to ~~an adverse determination or experimental treatment~~ a coverage denial determination, the independent review organization shall provide written notification to the commissioner, the insured, or the insured's authorized representative, and the insurer of its determination within 2 business days.

(e) 7. Medical or scientific evidence including evidence that is determined to be an efficacious treatment or strategy as defined at s. Ins 3.36 (3) (c), as appropriate.

SECTION 10. Ins 18.12 (1) (e) 8., is created to read:

Ins 18.12 (1) (e) 8. Legal basis, as appropriate.

SECTION 11. Ins 18.12 (1) (k), is created to read:

Ins 18.12 (1) (k) Procedures for determining when the inclusion of an attorney or actuary as a member of a review panel or the advice of an attorney and actuary would provide appropriate and necessary assistance in the review.

SECTION 12. Ins 18.12 (4), and (5), are amended to read:

Ins 18.12 (4) REVIEWER QUALIFICATIONS. (a) In addition to the requirements of s. 632.835 (6m), Stats., the independent review organization shall require all clinical peer reviewers assigned to conduct independent reviews to be physicians or other appropriate health care providers whose qualifications are verified at least every 2 years.

(b) For coverage denial determinations that include a legal review, the independent review organization shall require legal reviewers assigned to conduct independent reviews be attorneys licensed and in good standing in this state and whose qualifications are verified at least every 2 years.

(c) For coverage denial determinations that include review of an underwriting determination, the independent review organization shall require actuaries be assigned to assist in the review and be a member in good standing of the American academy of actuaries and whose qualifications are verified at least every 2 years.

(5) CONFLICT OF INTEREST. In addition to the requirements in s. 632.835 (6), Stats., all clinical peer, legal and actuary reviewers shall, at least quarterly, provide to the independent review organization a list of potential conflicts of interest.

SECTION 13. Ins 18.12 (6m) is created to read:

(6m) An independent review organization may employ or contract with a law firm, experienced attorney, actuarial entity or experienced actuary to assist in the review of matters related to reformations, rescissions and preexisting condition denial determinations. The independent review organization shall oversee aspects of quality assurance, licensing and expertise of the legal or actuarial reviewer.

SECTION 14. Ins 18.13 is created to read:

Ins 18.13 STANDARDS OF INDEPENDENT REVIEW. (1) For coverage denial determinations other than experimental treatment determinations, independent review organizations shall consider any of the following:

(a) Medical or scientific evidence including evidence that is determined to be an efficacious treatment or strategy as defined at s. Ins 3.36 (3) (c).

- (b) Legal basis.
- (c) The applicable insurance contract.

(2) Independent review organizations shall include as members or advisors an attorney or actuary when the dispute involves a rescission, reformation or the dispute includes a legal dispute. The addition of an attorney or actuary to a review panel is at the discretion of the independent review organization or reviewers and need only be considered when the independent review organization or reviewers determine additional expertise would provide appropriate and necessary assistance in the review.

SECTION 15. Ins 18.16 (2) (e), is amended to read:

Ins 18.16 (2) (e) The number of requests for independent review resolved and, of those resolved, the number resolved upholding the ~~adverse determination or experimental treatment~~ coverage denial determination by the insurer and the number resolved reversing the ~~adverse determination or experimental treatment~~ coverage denial determination by the insurer.

SECTION 16. Ins 18.16 (2) (em) is created to read:

Ins 18.16 (em) The names and specialty of the reviewers participating in reviews conducted during the year. The listing shall include the name of any attorney or actuary or the respective firm, who participated in the reviews.

SECTION 17. Ins 18.16 (2) (i), is amended to read:

Ins 18.16 (2) (i) The number of independent reviews that were terminated as the result of reconsideration by the insurer offering a health benefit plan of its ~~adverse determination or experimental treatment~~ coverage denial determination after the receipt of additional information from the insured, the insured's authorized representative, or other appropriate sources.

SECTION 18. Ins 18.18 (5) is repealed.

SECTION 19. Ins 18.18 (6) is amended to read.

Ins 18.18 (6) If an independent review organization determines the matter is not within its authority to review, it may not charge ~~no more than the filing fee~~ for that determination.

SECTION 20. This section may be enforced under s. 601.41, 601.64, 601.65 and 628.10, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

SECTION 21. These changes will take effect on the first day of the month after publication, as provided in s. 227.22 (2) (intro.), Stats.

Dated at Madison, Wisconsin, this _____ day of August, 2010.

Sean Dilweg
Commissioner of Insurance

**Office of the Commissioner of Insurance
Private Sector Fiscal Analysis**

for Section Ins 18 subchapter III relating to independent review procedures
and affecting small business

This rule change will have no significant effect on the private sector regulated by OCI.

FISCAL ESTIMATE WORKSHEET

Detailed Estimate of Annual Fiscal Effect

ORIGINAL UPDATED
 CORRECTED SUPPLEMENTAL

LRB Number	Amendment No. if Applicable
Bill Number	Administrative Rule Number INS 18III

Subject
independent review procedures and affecting small business

One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):
None

Annualized Costs:	Annualized Fiscal impact on State funds from:	
	Increased Costs	Decreased Costs
A. State Costs by Category		
State Operations - Salaries and Fringes	\$ 0	\$ -0
(FTE Position Changes)	(0 FTE)	(-0 FTE)
State Operations - Other Costs	0	-0
Local Assistance	0	-0
Aids to Individuals or Organizations	0	-0
TOTAL State Costs by Category	\$ 0	\$ -0
B. State Costs by Source of Funds		
GPR	\$ 0	\$ -0
FED	0	-0
PRO/PRS	0	-0
SEG/SEG-S	0	-0
C. State Revenues <small>Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, etc.)</small>	Increased Rev.	Decreased Rev.
GPR Taxes	\$ 0	\$ -0
GPR Earned	0	-0
FED	0	-0
PRO/PRS	0	-0
SEG/SEG-S	0	-0
TOTAL State Revenues	\$ 0 None	\$ -0 None

NET ANNUALIZED FISCAL IMPACT

	<u>STATE</u>	<u>LOCAL</u>
NET CHANGE IN COSTS	\$ <u>None 0</u>	\$ <u>None 0</u>
NET CHANGE IN REVENUES	\$ <u>None 0</u>	\$ <u>None 0</u>

Prepared by: Julie E. Walsh	Telephone No. (608) 264-8101	Agency Insurance
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Authorized Signature:

Telephone No.

Date (mm/dd/ccyy)

