

1989 Senate Bill 143

Date of enactment: **June 30, 1989**
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1989 WISCONSIN ACT 23

AN ACT *to repeal* 601.42 (1); *to renumber* 609.01 (1), 645.08 and 645.58; *to renumber and amend* 646.31 (3) (a); *to amend* 185.983 (1) (intro.), 600.03 (25) (a) (intro.) and 1, 601.42 (1g) (intro.), (a) and (b), 601.43 (1) (b) 4, 609.01 (6), 613.03 (3), 623.11 (1) (intro.) and (2) (intro.), 645.04 (3), 645.06, 645.08 (title), 645.42 (1), 645.58 (title), 645.62 (1) (a) (intro.), 645.68 (3) and (5), 646.01 (1) (a) 2. a, 646.11 (2) and (5), 646.31 (3) (b) and 646.51 (3) (a) 1; *to repeal and recreate* 185.983 (1) (intro.) and 646.01 (1) (a) 2. e; and *to create* 49.49 (3p), 600.03 (23c) and (23g), 600.03 (25) (a) 3, 601.42 (1g) (d), 609.01 (1), (1d), (1j) and (5m), 609.03, 609.91 to 609.98, 611.19 (8), 613.19 (6), 614.19 (5), 623.11 (3), 632.795, 645.035, 645.08 (1) (title) and (2), 645.31 (15), 645.58 (1) (title) and (2), 645.69, 646.01 (1) (b) 14, 646.31 (1) (d) 8 and 9, 646.31 (3) (a), 646.31 (3) (c) and 646.35 (6) (bm) of the statutes, **relating to:** financial requirements for health maintenance organizations, limiting the liability of enrollees and policyholders of health maintenance organizations for covered health care costs, open enrollment for persons insured under a liquidated insurer's group health policy, special deposits by health maintenance organizations, eligibility of and deductibles for claims under the insurance security fund, other changes to the laws governing health maintenance organizations and insurer delinquency proceedings and granting rule-making authority.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 49.49 (3p) of the statutes is created to read:

49.49 (3p) OTHER PROHIBITED PROVIDER CHARGES. No provider may knowingly violate s. 609.91 (2).

SECTION 2. 185.983 (1) (intro.) of the statutes is amended to read:

185.983 (1) (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 632.79, 632.795, 632.87 (2m) and (3) and 632.895 (5), subch. II of ch. 619 and chs. 609, 630 and 645, but the sponsoring association shall:

SECTION 3. 185.983 (1) (intro.) of the statutes, as affected by 1987 Wisconsin Act 325, is repealed and recreated to read:

185.983 (1) (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646,

with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 632.79, 632.795, 632.87 (2m) and (3) and 632.895 (5), subch. II of ch. 619 and chs. 609, 630, 645 and 646, but the sponsoring association shall:

SECTION 4. 600.03 (23c) and (23g) of the statutes are created to read:

600.03 (23c) "Health maintenance organization insurer" means an insurer that satisfies all of the following:

(a) Is licensed under ch. 611, 613 or 614, issued a certificate of authority under ch. 618 or organized under ss. 185.981 to 185.985.

(b) Has a certificate of authority, an amended certificate of authority or a statement of operations issued by the commissioner under s. 609.03 that restricts the insurer to engaging in only the types of insurance business described in s. 609.03 (3).

(23g) "Individual practice association" means a person, other than a hospital, clinic or an individual physi-

cian or other individual health care provider, that does all of the following:

(a) Contracts with a health maintenance organization, limited service health organization or preferred provider plan, as defined in s. 609.01, to provide health care services.

(b) Provides health care services primarily through health care providers who are independent contractors or who are obligated to provide the services because of membership in the entity.

SECTION 5. 600.03 (25) (a) (intro.) and 1 of the statutes are amended to read:

600.03 (25) (a) (intro.) “Insurance” includes any of the following:

1. Risk distributing arrangements providing for compensation of damages or loss through the provision of services or benefits in kind rather than indemnity in money;

SECTION 6. 600.03 (25) (a) 3. of the statutes is created to read:

600.03 (25) (a) 3. Plans established and operated under ss. 185.981 to 185.985.

SECTION 7. 601.42 (1) of the statutes is repealed.

SECTION 8. 601.42 (1g) (intro.), (a) and (b) of the statutes are amended to read:

601.42 (1g) **REPORTS.** (intro.) The commissioner may require any of the following from any person subject to regulation under chs. 600 to 647:

(a) Statements, reports, answers to questionnaires and other information, and evidence thereof, in whatever reasonable form the commissioner designates, and at such reasonable intervals as the commissioner chooses, or from time to time;

(b) Full explanation of the programming of any data storage or communication system in use; ~~and~~

SECTION 9. 601.42 (1g) (d) of the statutes is created to read:

601.42 (1g) (d) Statements, reports, answers to questionnaires or other information, or reports, audits or certification from a certified public accountant or an actuary approved by the commissioner, relating to the extent liabilities of a health maintenance organization insurer are or will be covered liabilities, as defined in s. 609.01 (1).

SECTION 10. 601.43 (1) (b) 4. of the statutes is amended to read:

601.43 (1) (b) 4. An individual practice association, ~~as defined in s. 601.42 (1),~~ which contracts with the examinee to provide health care services.

SECTION 11. 609.01 (1) of the statutes is renumbered 609.01 (1m).

SECTION 12. 609.01 (1), (1d), (1j) and (5m) of the statutes are created to read:

609.01 (1) “Covered liability” means liability of a health maintenance organization insurer for health care costs for which an enrolled participant or policyholder of

the health maintenance organization insurer is not liable to any person under s. 609.91.

(1d) “Enrolled participant” means a person entitled to health care services under an individual or group policy issued by a health maintenance organization, limited service health organization or preferred provider plan.

(1j) “Health care costs” means consideration for the provision of health care, including consideration for services, equipment, supplies and drugs.

(5m) “Provider” means a health care professional, a health care facility or a health care service or organization.

SECTION 13. 609.01 (6) of the statutes is amended to read:

609.01 (6) “Selected provider” means a provider, ~~as defined in s. 628.36 (2) (a) 2,~~ selected by a health maintenance organization, limited service health organization or preferred provider plan to perform health care services for enrolled participants.

SECTION 14. 609.03 of the statutes is created to read:

609.03 Indication of operations. (1) **CERTIFICATE OF AUTHORITY.** An insurer may apply to the commissioner for a new or amended certificate of authority that limits the insurer to engaging in only the types of insurance business described in sub. (3).

(2) **STATEMENT OF OPERATIONS.** If an insurer is a cooperative association organized under ss. 185.981 to 185.985, the insurer may apply to the commissioner for a statement of operations that limits the insurer to engaging in only the types of insurance business described in sub. (3).

(3) **RESTRICTIONS ON OPERATIONS.** (a) An insurer that has a new or amended certificate of authority under sub. (1) or a statement of operations under sub. (2) may engage in only the following types of insurance business:

1. As a health maintenance organization.
2. As a limited service health organization.
3. In other insurance business that is immaterial in relation to, or incidental to, the insurer’s business under subd. 1 or 2.

(b) The commissioner may, by rule, define “immaterial” or “incidental”, or both, for purposes of par. (a) 3. as a percentage of premiums, except the percentage may not exceed 10% of the total premiums written by the insurer.

(4) **REMOVING RESTRICTIONS.** An amendment to a certificate of authority or statement of operations that removes the limitation imposed under this section is not effective unless the insurer, on the effective date of the amendment, complies with the capital, surplus and other requirements applicable to the insurer under chs. 600 to 645.

SECTION 15. 609.91 to 609.98 of the statutes are created to read:

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609.91 Restrictions on recovering health care costs. (1) IMMUNITY OF ENROLLED PARTICIPANTS AND POLICYHOLDERS. Except as provided in sub. (1m), an enrolled participant or policyholder of a health maintenance organization insurer is not liable for health care costs that are incurred on or after January 1, 1990, and that are covered under a policy or certificate issued by the health maintenance organization insurer, if any of the following applies:

(a) The health care is provided by a provider who satisfies any of the following:

1. Is an affiliate of the health maintenance organization insurer.
2. Owns at least 5% of the voting securities of the health maintenance organization insurer.
3. Is entitled, alone or with one or more affiliates, to solely select one or more board members of the health maintenance organization insurer, or has an affiliate that is entitled to solely select one or more board members of the health maintenance organization insurer.
4. Is entitled to have one or more board members of the health maintenance organization insurer serve exclusively as a representative of the provider, one or more of the provider's affiliates or the provider and its affiliates, except this subdivision does not apply to an individual practice association or an affiliate of an individual practice association.
5. Is an individual practice association that is represented, or its affiliate is represented, on the board of the health maintenance organization insurer, and at least 3 of the board members of the health maintenance organization represent one or more individual practice associations.

(am) The health care is provided by a provider under a contract with, or through membership in, a person who satisfies par. (a) 1., 2., 3, 4 or 5.

(b) The health care is provided by a provider who is not subject to par. (a) or (am) and who does not elect to be exempt from this paragraph under s. 609.92, and the health care satisfies any of the following:

1. Is provided by a hospital or an individual practice association.
2. Is physician services provided under a contract with the health maintenance organization insurer or by a selected provider of the health maintenance organization insurer.
3. Is services, equipment, supplies or drugs that are ancillary or incidental to services described in subd. 2 and are provided by the contracting provider or selected provider.

(c) The health care is provided by a provider who is not subject to par. (a), (am) or (b) with regard to that health care and who elects under s. 609.925 to be subject to this paragraph.

(d) The liability is for the portion of health care costs that exceeds the amount that the health maintenance

organization insurer has agreed, in a contract with the provider of the health care, to pay the provider for that health care.

(1m) IMMUNITY OF MEDICAL ASSISTANCE RECIPIENTS. An enrolled participant, policyholder or insured under a policy issued by an insurer to the department of health and social services under s. 49.45 (2) (b) 2. to provide pre-paid health care to medical assistance recipients is not liable for health care costs that are covered under the policy.

(2) PROHIBITED RECOVERY ATTEMPTS. No person may bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency or have any recourse against an enrolled participant, policyholder or insured, or any person acting on their behalf, for health care costs for which the enrolled participant, policyholder or insured, or person acting on their behalf, is not liable under sub. (1) or (1m).

(3) DEDUCTIBLES, COPAYMENTS AND PREMIUMS. Subsections (1) to (2) do not affect the liability of an enrolled participant, policyholder or insured for any deductibles, copayments or premiums owed under the policy or certificate issued by the health maintenance organization insurer or by the insurer described in sub. (1m).

(4) CONDITIONS NOT AFFECTING THE IMMUNITY. The immunity of an enrolled participant, policyholder or insured for health care costs, to the extent of the immunity provided under this section and ss. 609.92 to 609.935, is not affected by any of the following:

(a) An agreement, other than a notice of election or termination of election in accordance with s. 609.92 or 609.925, entered into by the provider, the health maintenance organization insurer, the insurer described in sub. (1m) or any other person, at any time, whether oral or written and whether implied or explicit, including an agreement that purports to hold the enrolled participant, policyholder or insured liable for health care costs.

(b) A breach of or default on an agreement by the health maintenance organization insurer, the insurer described in sub. (1m) or any other person to compensate the provider, directly or indirectly, for health care costs, including health care costs for which the enrolled participant, policyholder or insured is not liable under sub. (1) or (1m).

(c) The insolvency of the health maintenance organization insurer or any person contracting with the health maintenance organization insurer or provider, or the commencement or the existence of conditions permitting the commencement of insolvency, delinquency or bankruptcy proceedings involving the health maintenance organization insurer or other person, including delinquency proceedings, as defined in s. 645.03 (1) (b), under ch. 645, despite whether the health maintenance organization insurer or other person has agreed to compensate, directly or indirectly, the provider for health care

costs for which the enrolled participant or policyholder is not liable under sub. (1).

(cm) The insolvency of the insurer described in sub. (1m) or any person contracting with the insurer or provider, or the commencement or the existence of conditions permitting the commencement of insolvency, delinquency or bankruptcy proceedings involving the insurer or other person, including delinquency proceedings, as defined in s. 645.03 (1) (b), under ch. 645, despite whether the insurer or other person has agreed to compensate, directly or indirectly, the provider for health care costs for which the enrolled participant, policyholder or insured is not liable under sub. (1m).

(d) The inability of the provider or other person who is owed compensation for health care costs to obtain compensation from the health maintenance organization insurer, the insurer described in sub. (1m) or any other person for health care costs for which the enrolled participant, policyholder or insured is not liable under sub. (1) or (1m).

(e) The failure of a health maintenance organization insurer to comply with s. 609.94.

(f) Any other conditions or agreements, other than a notice of election or termination of election in accordance with s. 609.92 or 609.925, existing at any time.

609.92 Hospitals, individual practice associations and providers of physician services. (1) ELECTION OF EXEMPTION. Except as provided in s. 609.93, a hospital, an individual practice association or other provider described in s. 609.91 (1) (b) may elect to be exempt from s. 609.91 (1) (b) for the purpose of recovering health care costs arising from health care provided by the hospital, individual practice association or other provider, if the conditions under sub. (2) or (3), whichever is applicable, are satisfied.

(2) CARE PROVIDED UNDER A CONTRACT. If the health care is provided under a written contract between a health maintenance organization insurer and the hospital, individual practice association or other provider, all of the following conditions must be met for the hospital, individual practice association or other provider to secure an exemption under sub. (1):

(a) The contract must be in effect on the date that the health care is provided, and the health care must be provided in accordance with the terms of the contract.

(b) The hospital, individual practice association or other provider must, within 30 days after entering into the contract, deliver to the office a written notice stating that the hospital, individual practice association or other provider elects to be exempt from s. 609.91 (1) (b). The notice shall comply with the rules, if any, promulgated under s. 609.935.

(3) CARE PROVIDED WITHOUT A CONTRACT. If the health care is not provided under a contract that satisfies sub. (2), all of the following conditions must be met for

the hospital, individual practice association or other provider to secure an exemption under sub. (1):

(a) The hospital, individual practice association or other provider must deliver to the office a notice stating that the hospital, individual practice association or other provider elects to be exempt from s. 609.91 (1) (b) with respect to a specified health maintenance organization insurer. The notice shall comply with the rules, if any, promulgated under s. 609.935.

(b) If the health care is provided on or after January 1, 1990, and before January 1, 1991, the health care must be provided at least 60 days after the office receives the notice under par. (a).

(c) If the health care is provided on or after January 1, 1991, the health care must be provided at least 90 days after the office receives the notice under par. (a).

(4) TERMINATION OF ELECTION. A hospital, individual practice association or other provider may terminate its election under sub. (2) or (3) by stating the termination date in the notice under sub. (2) or (3) or in a separate written termination notice filed with the office. The termination notice shall comply with the rules, if any, promulgated under s. 609.935. The termination is effective for any health care costs incurred after the termination date specified in the notice or the date on which the notice is filed, whichever is later.

(5) PROVIDER OF PHYSICIAN SERVICES. A provider who is not under contract with a health maintenance organization insurer and who is not a selected provider of a health maintenance organization insurer is not subject to s. 609.91 (1) (b) 2. with respect to health care costs incurred by an enrolled participant of that health maintenance organization insurer.

609.925 Election to be subject to restrictions. (1) NOTICE OF ELECTION. Except as provided in s. 609.93, a provider described in s. 609.91 (1) (c) is subject to s. 609.91 (1) (c) for purposes of recovering health care costs arising from health care provided by the provider, if the provider files with the office a written notice stating that the provider elects to be subject to s. 609.91 (1) (c) with respect to a specified health maintenance organization insurer. The notice shall comply with the rules, if any, promulgated under s. 609.935. The notice is effective on the date that it is received by the office or the date specified in the notice, whichever is later.

(2) TERMINATION OF ELECTION. A provider may terminate a notice of election under sub. (1) by stating the termination date in the notice of election or in a separate written termination notice filed with the office. The termination notice shall comply with the rules, if any, promulgated under s. 609.935. The termination date may not be earlier than 90 days after the office receives notice of termination, whether included in the notice of election or in a separate termination notice.

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(3) **EFFECTIVE PERIOD OF ELECTION.** Section 609.91 applies to health care costs incurred on and after the effective date of the notice under sub. (1) or January 1, 1990, whichever is later, and until the termination date of the notice.

609.93 Scope of election by an individual practice association or clinic. (1) **INDIVIDUAL PRACTICE ASSOCIATION.** The election by an individual practice association under s. 609.92 to be exempt from s. 609.91 (1) (b) or the failure of the individual practice association to so elect applies to health care costs arising from health care provided by any provider, other than a hospital, under a contract with, or through membership in, the individual practice association. A provider, other than a hospital, may not exercise an election under s. 609.92 or 609.925 separately from an individual practice association with respect to health care costs arising from health care provided under a contract with, or through membership in, the individual practice association.

(2) **CLINICS.** (a) The election by a clinic under s. 609.92 to be exempt from s. 609.91 (1) (b) with respect to services described in s. 609.91 (1) (b) 2. and 3. or the failure of the clinic to so elect, or the election by a clinic under s. 609.925 to be subject to s. 609.91 (1) (c) or the failure of the clinic to so elect, applies to health care costs arising from health care provided by any provider through the clinic. A provider may not exercise an election under s. 609.92 or 609.925 separately from the clinic with respect to health care costs provided through the clinic.

(b) The commissioner may, by rule, specify the types of health care facilities or organizations that qualify as clinics for purposes of this subsection.

609.935 Notices of election and termination. (1) **IN ACCORDANCE WITH RULES.** If the commissioner promulgates rules governing the form or manner of filing a notice of election or termination notice under s. 609.92 or 609.925, a notice of election or termination notice filed after the rules take effect is not effective unless filed in accordance with the applicable rules.

(2) **EFFECT OF CERTAIN CHANGES.** The effectiveness of a notice of election or termination notice filed with the office under s. 609.92 or 609.925 is not affected by the renaming, reorganization, merger, consolidation or change in control of the provider, health maintenance organization insurer or any other person. The commissioner may, by rule, require a provider to amend a notice of election or termination notice if any of the events in this subsection or other changes affecting the accuracy of the information occur.

609.94 Summary of restrictions. (1) A health maintenance organization insurer shall deliver a written notice that complies with sub. (2) to all of the following:

(a) Each provider that contracts with the health maintenance organization insurer to provide health care ser-

vices, at the time that the health maintenance organization insurer and provider enter into a contract.

(b) Each selected provider of the health maintenance organization insurer, at the time that the provider becomes a selected provider.

(2) The notice shall contain a summary of ss. 609.91 to 609.935 and 609.97 (1) and a statement that the health maintenance organization insurer files financial statements with the office which are available for public inspection. The commissioner may, by rule, specify a form for providing the notice required under this section. If the commissioner promulgates such a rule, any notice delivered on or after the effective date of the rule shall comply with the form specified by rule.

609.95 Minimum covered liabilities. A health maintenance organization insurer, whether first licensed or organized before, on or after the effective date of this section [revisor inserts date], shall maintain, on and after January 1, 1990, at least 65% of its liabilities for health care costs as covered liabilities.

609.96 Initial capital and surplus requirements.

(1) **MINIMUM CAPITAL AND PERMANENT SURPLUS.** (a) Except as provided in par. (b), if a health maintenance organization insurer is first licensed or organized on or after the effective date of this paragraph [revisor inserts date], the minimum capital or permanent surplus for the health maintenance organization insurer is \$750,000.

(b) The commissioner may require a greater amount or permit a lesser amount than that specified under sub. (1) by rule promulgated, or order issued, on or after the effective date of this paragraph [revisor inserts date].

(2) **INITIAL EXPENDABLE SURPLUS.** A health maintenance organization insurer subject to sub. (1) shall have an initial expendable surplus, after payment of all organizational expenses, of at least 50% of the minimum capital or minimum permanent surplus required under sub. (1), or such other percentage as the commissioner specifies by rule promulgated, or order issued, on or after the effective date of this subsection [revisor inserts date].

609.97 Compulsory and security surplus. (1) **AMOUNT OF COMPULSORY SURPLUS.** Except as otherwise provided by rule or order under sub. (2), a health maintenance organization insurer, whether first licensed or organized before, on or after the effective date of this subsection [revisor inserts date], shall maintain a compulsory surplus in an amount determined as follows:

(a) Beginning on the effective date of this paragraph [revisor inserts date], and ending on December 31, 1989, the compulsory surplus shall be equal to at least the greater of \$200,000 or 3% of the premiums earned by the health maintenance organization insurer in the previous 12 months.

(b) Beginning on January 1, 1990, and ending on December 31, 1991, the compulsory surplus shall be equal to at least the greater of \$500,000 or:

1. If before January 1, 1991, 3% of the premiums earned by the health maintenance organization insurer in the previous 12 months.

2. If on or after January 1, 1991:

a. If the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is less than 90%, 4.5% of the premiums earned by the health maintenance organization insurer in the previous 12 months.

b. If the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is at least 90%, 3% of the premiums earned by the health maintenance organization insurer in the previous 12 months.

(c) Beginning on January 1, 1992, the compulsory surplus shall be equal to at least the greater of \$750,000 or:

1. If the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is less than 90%, 6% of the premiums earned by the health maintenance organization insurer in the previous 12 months.

2. If the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is at least 90%, 3% of the premiums earned by the health maintenance organization insurer in the previous 12 months.

(2) **MODIFICATION BY RULE OR ORDER.** The commissioner may require a greater amount or permit a lesser amount than that specified under sub. (1) by rule promulgated, or order issued, on or after the effective date of this subsection [revisor inserts date]. The commissioner may consider the risks and factors described under s. 623.11 (1) (a) and (b) in promulgating a rule or issuing an order under this subsection.

(3) **AMOUNT OF SECURITY SURPLUS.** A health maintenance organization insurer, whether first licensed or organized before, on or after the effective date of this subsection [revisor inserts date], shall maintain a security surplus in the amount set by the commissioner under s. 623.12.

609.98 Special deposit. (1) **DEFINITION.** In this section, “premiums” has the meaning given under s. 646.51 (3) (a) 1.

(2) **DUTY; AMOUNT.** (a) Before April 1, 1990, and before April 1 of each following year, a health maintenance organization insurer shall deposit under s. 601.13 an amount that is at least equal to the lesser of the following:

1. An amount necessary to establish or maintain a deposit equaling 1% of premiums written in this state by the health maintenance organization insurer in the preceding calendar year.

2. With respect to the amount due before April 1, 1990, 0.5% of premiums written in this state by the health maintenance organization insurer in the preceding calendar year, unless otherwise provided by rule or order under par. (b).

3. With respect to the amount due in the years after 1990, one-third of 1% of the premiums written in this state by the health maintenance organization insurer in the preceding calendar year, unless otherwise provided by rule or order under par. (b).

(b) The commissioner may, by rule or order, require that the deposit under par. (a) be in an amount greater than that provided under par. (a) 2. or 3., but the commissioner may not require an amount exceeding the amount provided under par. (a) 1.

(3) **STATUS OF DEPOSIT.** A deposit under this section is in addition to any deposit otherwise required or permitted by law or the commissioner. An amount deposited under this section is not available for the purpose of determining permanent capital or surplus, compulsory surplus or the financial condition, including insolvency, of the health maintenance organization insurer.

(4) **RELEASE OF DEPOSIT.** A deposit under this section may be released only with the approval of the commissioner under s. 601.13 (10) and only in any of the following circumstances:

(a) To pay an assessment under s. 646.51 (3) (a) or (b).

(b) To the extent that the amount on deposit exceeds 1% of premiums written in this state by the health maintenance organization insurer in the preceding calendar year and the deposit is not necessary to pay an assessment under s. 646.51 (3) (a) or (b).

(c) To pay claimants and creditors as provided by s. 601.13 (2).

SECTION 16. 611.19 (8) of the statutes is created to read:

611.19 (8) **HEALTH MAINTENANCE ORGANIZATION INSURER.** This section does not apply to a health maintenance organization insurer that is subject to s. 609.96.

SECTION 17. 613.03 (3) of the statutes is amended to read:

613.03 (3) **APPLICABILITY OF INSURANCE LAWS.** Except as otherwise specifically provided, service insurance corporations organized or operating under this chapter are subject to subch. II of ch. 619 and ss. 610.01, 610.11, 610.21, 610.23 and 610.24 and chs. 600, 601, 609, 617, 620, 623, 625, 627, 628, 631, 632 and 645 and to no other insurance laws.

SECTION 18. 613.19 (6) of the statutes is created to read:

613.19 (6) **HEALTH MAINTENANCE ORGANIZATION INSURER.** This section does not apply to a health maintenance organization insurer that is subject to s. 609.96.

SECTION 19. 614.19 (5) of the statutes is created to read:

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614.19 (5) HEALTH MAINTENANCE ORGANIZATION INSURER. This section does not apply to a health maintenance organization insurer that is subject to s. 609.96.

SECTION 20. 623.11 (1) (intro.) and (2) (intro.) of the statutes are amended to read:

623.11 (1) DETERMINATION OF AMOUNT. (intro.) The Except as provided in sub. (3), the commissioner shall, when necessary, determine the amount of compulsory surplus that an insurer is required to have in order not to be financially hazardous under s. 645.41 (4), as an amount that will provide reasonable security against contingencies affecting the insurer's financial position that are not fully covered by reserves or by reinsurance.

(2) RULES. (intro.) The Except as provided in sub. (3), the commissioner may, subject to adjustment to the circumstances of individual insurers in accordance with the factors in sub. (1) (b), establish by rule minimum ratios for the compulsory surplus in relation to any relevant variables, including the following:

SECTION 21. 623.11 (3) of the statutes is created to read:

623.11 (3) HEALTH MAINTENANCE ORGANIZATION INSURERS. The amount of compulsory surplus required of a health maintenance organization insurer is the amount provided in s. 609.97.

SECTION 22. 632.795 of the statutes is created to read:

632.795 Open enrollment upon liquidation. (1) DEFINITION. In this section, "liquidated insurer" means an insurer ordered liquidated under ch. 645 or under similar laws of another jurisdiction.

(2) COVERAGE FOR GROUP MEMBERS. Except as provided in sub. (5) and unless otherwise provided by rule or order of the commissioner, an insurer described in sub. (3) shall permit insureds or enrolled participants of a liquidated insurer's group health care policy or plan to obtain coverage under a comprehensive group health care policy or plan offered by the insurer in the manner and under the terms required by sub. (4).

(3) PARTICIPATING INSURERS. Subsection (2) applies to an insurer that participated in the most recent enrollment period in which the group members were able to choose among coverage offered by the liquidated insurer and coverage offered by one or more other insurers, if all of the following are satisfied:

(a) Coverage under a comprehensive group health care policy or plan offered by the insurer was selected by one or more members of the group in the most recent enrollment period.

(b) The most recent enrollment period occurred on or after the effective date of this paragraph [revisor inserts date].

(4) TERMS AND OFFERING OF COVERAGE. (a) An insurer subject to sub. (2) shall provide coverage under the same policy form and for the same premium as it originally offered in the most recent enrollment period, subject only to the medical underwriting used in that enroll-

ment period. Unless otherwise prescribed by rule, the insurer may apply deductibles, preexisting condition limitations, waiting periods or other limits only to the extent that they would have been applicable had coverage been extended at the time of the most recent enrollment period and with credit for the satisfaction or partial satisfaction of similar provisions under the liquidated insurer's policy or plan. The insurer may exclude coverage of claims that are payable by a solvent insurer under insolvency coverage required by the commissioner or by the insurance regulator of another jurisdiction. Coverage shall be effective on the date that the liquidated insurer's coverage terminates.

(b) An insurer subject to sub. (2) shall offer coverage to the group members, and the policyholder shall provide group members with the opportunity to obtain coverage, in the manner and within the time limits required by the commissioner by rule or order.

(5) MEDICAL ASSISTANCE ENROLLEES. This section does not apply to persons enrolled in a health care plan offered by a liquidated insurer if the persons are enrolled in that plan under a contract between the department of health and social services and the liquidated insurer under s. 49.45 (2) (b) 2.

SECTION 22m. 645.035 of the statutes is created to read:

645.035 Bankruptcy petition is prohibited. (1) In this section, "bankruptcy proceeding" means any proceeding under 11 USC 101 to 1330.

(2) No insurer may commence a bankruptcy proceeding in which the insurer is a debtor.

(3) No person, including an insurer, may commence a bankruptcy proceeding against an insurer.

(4) No board of directors, director or officer of an insurer may authorize the commencement of a bankruptcy proceeding in which the insurer is a debtor or the commencement of a bankruptcy proceeding against an insurer. Any act, resolution, filing or other matter that purports to authorize the commencement of a bankruptcy proceeding in which the insurer is a debtor or against an insurer is void and without effect.

(5) This section applies to all insurers, including but not limited to an insurer doing business as a health maintenance organization, as defined in s. 609.01 (2).

SECTION 23. 645.04 (3) of the statutes is amended to read:

645.04 (3) (title) EXCLUSIVENESS OF PROCEEDINGS; ARBITRATION CLAUSES. No court of this state has jurisdiction to entertain, hear or determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation or receivership of any insurer, or praying for an injunction or restraining order or other relief preliminary to, incidental to or relating to such proceedings other than in accordance with this chapter. An arbitration provision of any contract with an insurer that is subject to a delinquency proceeding under

subch. III is not enforceable unless the receiver elects to accept arbitration. Only the court that has jurisdiction of the delinquency proceeding may entertain, hear or determine any matter that otherwise would be subject to an arbitration provision.

SECTION 24. 645.06 of the statutes is amended to read:

645.06 Costs and expenses of litigation. In any proceeding or action brought by the commissioner or a receiver under this chapter, the court may award such costs and other expenses of litigation to the commissioner or receiver as justice requires, without regard to the limitations otherwise prescribed by law. ~~If costs and expenses are taxed against the commissioner, they shall be paid from the appropriation under s. 20.145 (1) (g).~~

SECTION 25. 645.08 (title) of the statutes is amended to read:

645.08 (title) Bonds; immunity.

SECTION 26. 645.08 of the statutes is renumbered 645.08 (1).

SECTION 27. 645.08 (1) (title) and (2) of the statutes are created to read:

645.08 (1) (title) BONDS.

(2) IMMUNITY. No civil cause of action may arise against and no civil liability may be imposed upon the state, commissioner, special deputy commissioner, rehabilitator or liquidator, or their employes or agents, or the insurance security fund under ch. 646 or its agents, employes, directors or contributor insurers, for an act or omission by any of them in the performance of their powers and duties under this chapter. This subsection does not apply to a civil cause of action arising from an act or omission that is criminal under ch. 943, if the cause of action is not barred or limited by common law, sovereign immunity, governmental immunity or otherwise by law.

SECTION 28. 645.31 (15) of the statutes is created to read:

645.31 (15) That the insurer is a health maintenance organization insurer that has violated s. 609.95 or 609.98.

SECTION 29. 645.42 (1) of the statutes is amended to read:

645.42 (1) ORDER TO LIQUIDATE. An order to liquidate the business of a domestic insurer shall appoint the commissioner and his or her successors in office liquidator and shall direct the liquidator forthwith to take possession of the assets of the insurer and to administer them under the orders of the court. The liquidator shall be vested by operation of law with the title to all of the property, contracts and rights of action and all of the books and records, wherever located, of the insurer ordered liquidated, wherever located and with all of the stock issued by the insurer and any cause of action that has or subsequently accrues to the holder of the stock, as of the date of the filing of the petition for liquidation. The liquidator may recover and reduce the same to possession except that ancillary receivers in reciprocal states shall have, as

to assets located in their respective states, the rights and powers which are prescribed in s. 645.84 (3) for ancillary receivers appointed in this state as to assets located in this state. The filing or recording of the order with any register of deeds in this state imparts the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that register of deeds.

SECTION 30. 645.58 (title) of the statutes is amended to read:

645.58 (title) Reinsurer's liability; arbitration clauses.

SECTION 31. 645.58 of the statutes is renumbered 645.58 (1).

SECTION 32. 645.58 (1) (title) and (2) of the statutes are created to read:

645.58 (1) (title) LIABILITY.

(2) ARBITRATION. After December 31, 1989, a domestic insurer may not enter into a reinsurance contract that contains an arbitration provision permitting its reinsurer to require arbitration of an action on or related to the contract when the domestic insurer is subject to a delinquency proceeding under this subchapter.

SECTION 33. 645.62 (1) (a) (intro.) of the statutes is amended to read:

645.62 (1) (a) (intro.) ~~Proof~~ Unless otherwise prescribed by the liquidator, a proof of claim shall consist of a verified statement that includes all of the following that are applicable:

SECTION 34. 645.68 (3) and (5) of the statutes are amended to read:

645.68 (3) LOSS CLAIMS. All claims under policies for losses incurred including third party claims, and all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property which are not under policies, except the first \$200 of losses otherwise payable to any claimant under this subsection. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds or investment values, shall be treated as loss claims. Claims may not be cumulated by assignment to avoid application of the \$200 deductible provision. That portion of any loss for which indemnification is provided by other benefits or advantages recovered or recoverable by the claimant shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment made by an employer to his employee shall be treated as a gratuity. The claims described in s. 645.69 are among the claims not subject to this subsection.

(5) RESIDUAL CLASSIFICATION. All other claims including claims of the federal or any state or local government, not falling within other classes under this section and claims described in s. 645.69. Claims, including those of any governmental body, for a penalty or forfeiture, shall be allowed in this class only to the extent of the

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pecuniary loss sustained from the act, transaction or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under sub. (8).

SECTION 35. 645.69 of the statutes is created to read:

645.69 Claims for certain health care costs. Unless a lower class is applicable, a claim is included among the claims that are subject to the classification under s. 645.68 (5) if the claim is any of the following:

(1) A claim against a health maintenance organization insurer or an insurer described in s. 609.91 (1m) for health care costs, as defined in s. 609.01 (1j), for which an enrolled participant, as defined in s. 609.01 (1d), policyholder or insured of the health maintenance organization insurer or other insurer is not liable under ss. 609.91 to 609.935.

(2) A claim for health care costs, as defined in s. 609.01 (1j), for which an enrolled participant, as defined in s. 609.01 (1d), or policyholder of a health maintenance organization is not liable for any reason.

SECTION 36. 646.01 (1) (a) 2. a of the statutes is amended to read:

646.01 (1) (a) 2. a. Fraternal that are not health maintenance organization insurers.

SECTION 37. 646.01 (1) (a) 2. e. of the statutes is repealed and recreated to read:

646.01 (1) (a) 2. e. Service insurance corporations that are not health maintenance organization insurers.

SECTION 38. 646.01 (1) (b) 14. of the statutes is created to read:

646.01 (1) (b) 14. A policy issued by an insurer to the department of health and social services under s. 49.45 (2) (b) 2. to provide prepaid health care to medical assistance recipients.

SECTION 39. 646.11 (2) and (5) of the statutes are amended to read:

646.11 (2) ACCOUNTS. The fund shall be composed of ~~5~~ 6 segregated accounts, one for life insurance, one for annuities, one for disability insurance other than policies issued or coverage provided by a health maintenance organization insurer, one for health maintenance organization insurers, one for all other kinds of insurance subject to this chapter and an administrative account.

(5) IMMUNITY. No cause of action of any nature may arise against and no liability may be imposed upon the fund, or its agents, employes, directors or contributor insurers, or the commissioner or the commissioner's agents, employes or representatives ~~of the commissioner,~~ for any act or omission by any of them in the performance of their powers and duties under this chapter.

SECTION 40. 646.31 (1) (d) 8. and 9. of the statutes are created to read:

646.31 (1) (d) 8. Made for health care costs, as defined in s. 609.01 (1j), for which an enrolled participant, as defined in s. 609.01 (1d), or policyholder of a

health maintenance organization insurer is not liable under ss. 609.91 to 609.935.

9. Made for health care costs, as defined in s. 609.01 (1j), for which an enrolled participant, as defined in s. 609.01 (1d), or policyholder of a health maintenance organization is not liable for any reason.

SECTION 41. 646.31 (3) (a) of the statutes is renumbered 646.31 (3) (am) and amended to read:

646.31 (3) (am) ~~Payment~~ Except as provided in pars. (b) and (c), payment under this chapter is limited to the amount by which the claim exceeds \$200. Claims may not be aggregated by assignment or otherwise for application of this deductible.

SECTION 42. 646.31 (3) (a) of the statutes is created to read:

646.31 (3) (a) In this subsection, "health insurance policy" does not include a policy providing income continuation coverage or benefits for loss of time.

SECTION 43. 646.31 (3) (b) of the statutes is amended to read:

646.31 (3) (b) With regard to contracts subject to s. 646.35 (2) or (3) other than health insurance policies, in lieu of the deductible under par. (a) ~~(am),~~ the board may impose a deductible not to exceed the lesser of 10% or \$200 on any claim or other benefit payment if the board deems the imposition of this deductible more equitable or practical than that under par. (a) ~~(am).~~

SECTION 44. 646.31 (3) (c) of the statutes is created to read:

646.31 (3) (c) A claim or other benefit payment under this chapter that is made under a health insurance policy may not be subject to the deductible under par. (am) or (b).

SECTION 45. 646.35 (6) (bm) of the statutes is created to read:

646.35 (6) (bm) For coverages continued pursuant to par. (b), the board may do any of the following:

1. Substitute a comprehensive health insurance policy approved by the commissioner for a health maintenance organization policy that is subject to sub. (2) or (3), and increase rates or premiums for the substituted coverage as provided in sub. (5).

2. Substitute for a limited service health organization policy that is subject to sub. (2) or (3) a health insurance policy that is approved by the commissioner and that covers substantially the same benefits as the limited service health organization policy, and increase rates or premiums for the substituted coverage as provided in sub. (5).

SECTION 46. 646.51 (3) (a) 1. of the statutes is amended to read:

646.51 (3) (a) 1. In this section, "premiums" means gross premiums and other considerations received for direct insurance and annuities, including considerations for a plan established under ss. 185.981 to 185.985, less return premiums and other considerations, dividends and

experience credits paid or credited to policyholders on the direct business. The term “premiums” does not include any amounts received for any contracts or for the portions of any contracts for which coverage is excluded under s. 646.01 (1) (b).

SECTION 47. Nonstatutory provisions; restrictions on recovering health care costs. (1) In this SECTION:

(a) “Health maintenance organization insurer” has the meaning given in section 600.03 (23c) of the statutes, as created by this act.

(b) “Individual practice association” has the meaning given in section 600.03 (23g) of the statutes, as created by this act.

(c) “Provider” has the meaning given in section 609.01 (5m) of the statutes, as created by this act.

(2) Notwithstanding section 609.92 (2) (b) of the statutes, as created by this act, if a hospital, individual practice association or other provider described in section 609.91 (1) (b) of the statutes, as created by this act, has a written contract with a health maintenance organization insurer to provide health care services and the contract was entered into on or before December 1, 1989, the hospital, individual practice association or other provider may secure an exemption under section 609.92 (1) of the statutes, as created by this act, for health care provided under the contract by delivering to the office of the commissioner of insurance, on or before January 1, 1990, a written notice stating that the hospital, individual practice association or other provider elects to be exempt from section 609.91 (1) (b) of the statutes, as created by this act, with respect to a specified health maintenance organization insurer. The notice may state a termination date for the election, as provided in section 609.92 (4) of the statutes, as created by this act. The notice shall comply with the rules, if any, promulgated under section 609.935 of the statutes, as created by this act.

(3) Notwithstanding section 609.94 (1) of the statutes, as created by this act, a health maintenance organization insurer shall deliver, within 120 days after the effective date of this subsection, a written notice that complies with section 609.94 (2) of the statutes, as created by this act, to each provider that, on the effective

date of this subsection, is a selected provider of the health maintenance organization insurer or has a contract with the health maintenance organization insurer to provide health care services.

SECTION 48. Initial applicability. (1) NEW LIQUIDATION PROCEEDINGS. (a) The treatment of sections 645.42 (1), 646.01 (1) (b) 14. and 646.31 (3) (a) and (b) of the statutes and the creation of section 646.31 (3) (c) of the statutes first apply to liquidation proceedings in which a liquidation order is issued on the effective date of this paragraph.

(b) The treatment of sections 646.01 (1) (a) 2. a and e. and 646.51 (3) (a) 1. of the statutes and the repeal and recreation of section 185.983 (1) (intro.) of the statutes first apply to liquidation proceedings in which a liquidation order is issued on the effective date of this paragraph.

(c) The treatment of section 646.11 (2) of the statutes first applies to liquidation proceedings in which a liquidation order is issued on January 1, 1991.

(2) PENDING LIQUIDATION PROCEEDINGS. (a) The treatment of sections 645.04 (3), 645.06, 645.62 (1) (a) (intro.), 645.68 (3) and (5), 645.69, 646.31 (1) (d) 8. and 9. and 646.35 (6) (bm) of the statutes first applies to liquidation proceedings pending on the effective date of this paragraph.

(b) The treatment of sections 645.08 (title) and 646.11 (5) of the statutes, the renumbering of section 645.08 of the statutes and the creation of section 645.08 (1) (title) and (2) of the statutes first apply to acts or omissions occurring on the effective date of this paragraph, regardless of whether the acts or omissions relate to a liquidation proceeding in which a liquidation order is issued before, on or after the effective date of this paragraph.

SECTION 49. Effective dates. This act takes effect on the day after publication, except as follows:

(1) The treatment of sections 646.01 (1) (a) 2. a and e. and 646.51 (3) (a) 1. of the statutes, the repeal and recreation of section 185.983 (1) (intro.) of the statutes and SECTION 48 (1) (b) of this act take effect on July 1, 1989, or the day after publication, whichever is later.

(2) The treatment of section 646.11 (2) of the statutes takes effect on January 1, 1991.