98-183 - MANAGED CARE PLANS - HEALTH INS. ORG. PLANS
3.4/3.5

LCRC FORM 2

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CLEARINGHOUSE REPORT TO AGENCY

[THIS REPORT HAS BEEN PREPARED PURSUANT TO S. 227.15, STATS. THIS IS A REPORT ON A RULE AS ORIGINALLY PROPOSED BY THE AGENCY; THE REPORT MAY NOT REFLECT THE FINAL CONTENT OF THE RULE IN FINAL DRAFT FORM AS IT WILL BE SUBMITTED TO THE LEGISLATURE. THIS REPORT CONSTITUTES A REVIEW OF, BUT NOT APPROVAL OR DISAPPROVAL OF, THE SUBSTANTIVE CONTENT AND TECHNICAL ACCURACY OF THE RULE.]

CLEARINGHOUSE RULE **98–183**

AN ORDER to repeal Ins 3.48, 3.50 and 3.52; to create Ins 3.67 and 6.11 (3) (b) 4. and chapter Ins 9, relating to revising requirements for managed care plans and limited service health organization plans to comply with recent changes in state laws.

Submitted by **OFFICE OF THE COMMISSIONER OF INSURANCE**

11–11–98 RECEIVED BY LEGISLATIVE COUNCIL.
12–10–98 REPORT SENT TO AGENCY.

RS:LR:jal;kjf

LEGISLATIVE COUNCIL RULES CLEARINGHOUSE REPORT

This rule has been reviewed by the Rules Clearinghouse. Based on that review, comments are reported as noted below:

1. STATUTORY AUTHORITY [s. 227.15 (2) (a)]

   Comment Attached YES ☑ NO ☐

2. FORM, STYLE AND PLACEMENT IN ADMINISTRATIVE CODE [s. 227.15 (2) (c)]

   Comment Attached YES ☑ NO ☐

3. CONFLICT WITH OR DUPLICATION OF EXISTING RULES [s. 227.15 (2) (d)]

   Comment Attached YES ☐ NO ☑

4. ADEQUACY OF REFERENCES TO RELATED STATUTES, RULES AND FORMS [s. 227.15 (2) (e)]

   Comment Attached YES ☑ NO ☐

5. CLARITY, GRAMMAR, PUNCTUATION AND USE OF PLAIN LANGUAGE [s. 227.15 (2) (f)]

   Comment Attached YES ☑ NO ☐

6. POTENTIAL CONFLICTS WITH, AND COMPARABILITY TO, RELATED FEDERAL REGULATIONS [s. 227.15 (2) (g)]

   Comment Attached YES ☐ NO ☑

7. COMPLIANCE WITH PERMIT ACTION DEADLINE REQUIREMENTS [s. 227.15 (2) (h)]

   Comment Attached YES ☐ NO ☑

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CLEARINGHOUSE RULE 98–183

Comments

[NOTE: All citations to "Manual" in the comments below are to the Administrative Rules Procedures Manual, prepared by the Revisor of Statutes Bureau and the Legislative Council Staff, dated September 1998.]

1. Statutory Authority

a. In s. Ins 3.67 (2) (a), an enrollee or his or her representative may request coverage of drug items not on a list of approved pharmaceuticals. However, under s. 632.853, Stats., the physician is required to present evidence of a patient needing an exception to the list of approved pharmaceuticals which may be used by health benefit plan participants. This rule paragraph should be revised accordingly.

b. In s. Ins 9.33 (2) (d), an insurer's report must demonstrate that emergency care is available 24 hours per day and seven days per week. This does not appear to be required by the statute. See s. 632.85 (2), Stats., which implies that emergency care is needed only if the plan "provides coverage of any emergency medical services." [See, also, s. 609.22 (6), Stats., as affected by 1997 Wisconsin Act 237.]

2. Form, Style and Placement in Administrative Code

a. SECTION 1 should read: "Ins 3.48, 3.50 and 3.52 are repealed."

b. Section Ins 9.01 should constitute subch. I of ch. Ins 9. The remaining subchapters should be renumbered accordingly.

c. Section Ins 9.04 (2) (a) should be split into two paragraphs. The new par. (b) should commence with the phrase "A health maintenance organization insurer shall maintain," because the requirements under current s. Ins 9.04 (2) (a) 1. and 2. apply only to health maintenance organization insurers. If this new paragraph is created, the subsequent paragraphs should be renumbered accordingly.

d. In s. Ins 9.04 (5) (a), a new par. (b) should be created beginning with the sentence "Health maintenance organization insurers and insurers licensed to write only limited service health organization business . . . ." Again, the material beginning with this sentence is a separate concept and requirement from the material in the first part of s. Ins 9.04 (5) (a).

e. In s. Ins 9.05 (1), an introductory clause should precede pars. (a) and (b) indicating that the business plan is required to include the information specified in "one of the following:". Paragraph (a) then should conclude with a period. Similarly, par. (b) should begin with an introductory clause and subds. 1. and 2. each should conclude with a period.

f. Section Ins 9.07 (1) should be split into two sentences. The second sentence should read: "This information shall be made available to the commissioner on request."

g. In s. Ins 9.08 (1), the term "Health Maintenance Organization" should not be capitalized. [See, also, ss. Ins 9.08 (4) and 9.39 (1) (a).]

h. In s. Ins 9.08 (1) (a) and (c), do not capitalize the word "Appendix." [See, also, s. Ins 9.13.]

i. In s. Ins 9.11, the acronym "IPA" is used. An acronym should be defined prior to the first time it is used. [See s. 1.01 (8), Manual.]

j. In s. Ins 9.41, the notation "(1)" should be deleted.

k. The rule does not contain an effective date clause. [See s. 1.02 (4), Manual.]

4. Adequacy of References to Related Statutes, Rules and Forms

a. In s. Ins 3.67 (4) (g), it appears that the word "paragraph" should be replaced by the word "subsection."

b. In s. Ins 9.01 (6), the notation "s." should be inserted before the reference to "HFS 124.24." [See, also, ss. Ins 9.08 (1) (c), 9.12 (3) and 9.41.]

c. In s. Ins 9.04, the introduction should conclude with a colon and, in sub. (1) (d), it appears that the reference "par. (1) (c)" should be replaced by a reference to "par. (c)."

d. In s. Ins 9.32 (1), "s. 609.15 (1a)" should read "s. 609.15 (1) (a)."

e. It would be useful in s. Ins 9.33 (2) to cross-reference sub. (1), which refers to the required annual certification on the numbers and types of providers.

f. It would be helpful in s. Ins 9.34 (1) to insert a cross-reference to s. 609.24, Stats., which contains the limitations on continuity of care.

g. The rule is replete with references to forms. The agency should ensure that the requirements of s. 227.14 (3), Stats., are met.

5. Clarity, Grammar, Punctuation and Use of Plain Language

a. In s. Ins 3.67 (1) (a) (intro.), the introductory paragraph and subsequent subds. 1., 2. and 3., do not agree with each other. The introductory paragraph should be rephrased to read as follows: "Expedited request" means a request where the standard resolution process may do any of the following:". Structural disagreements between introductory material and following subunits also can be found in ss. Ins 3.67 (4), 9.01 (3) and 9.04 (1).

b. In s. Ins 3.67 (3) (a), the term "health care plan" should be changed to "health benefit plan." The entire rule should be reviewed for the use of the defined term "health benefit plan."

c. Section Ins 9.01 (2) refers to an "enrollee," while sub. (4) refers to a "plan enrollee." Consistent terminology should be used.

d. Section Ins 9.01 should include a definition of the term "commissioner" and that term should be used consistently rather than using the terms "commissioner" and "office" interchangeably.

e. In the title to subch. I of ch. Ins 9, the title would be clearer if it stated something similar to "Financial Standards for Health Maintenance Organizations and Limited Service Health Organizations."

f. Section Ins 9.04 (intro.) should conclude with a colon.

g. Section Ins 9.04 (1) (d) should be incorporated into par. (c) since it only applies to insurers licensed to write only limited service health organization business.

h. In s. Ins 9.04 (1) (e), is the term "required surplus" supposed to be "permanent surplus"?

i. In s. Ins 9.04 (2) (a) (intro.), insert the word "a" between the words "maintain" and "compulsory."

j. In s. Ins 9.04 (2), since an insurer writing health maintenance organization business appears to be a different entity from a health maintenance organization insurer, perhaps both of these terms should be defined to improve the clarity of this subsection.

k. In s. Ins 9.04 (2) (b), the beginning of the second sentence should read: "The compulsory surplus shall be." Also, the semicolon in the last sentence should be deleted.

l. In s. Ins 9.04 (2) (c), insert "of securities" after the term "deposit" in the first line.

m. If s. Ins 9.04 (5) (a) (intro.) contains a requirement for health maintenance organization insurers and insurers licensed to write only limited service health organization business to maintain a security surplus, the word "should" should be deleted and replaced with the word "shall."

n. In s. Ins 9.04 (5) (b), the words "equal to" should be deleted. They are unnecessary.

o. In s. Ins 9.08 (3) (b), it appears that the correct reference should be to subs. (1) to (3). If so, subs. (4) and (5) can be collapsed into one subsection. Similarly, the paragraphs of sub. (3) can be combined into one subsection.

p. In s. Ins 9.09 (3), delete the comma after s. 609.92.

q. In s. Ins 9.10, delete the word "for" in the fourth line. [See, also, s. Ins 9.11.]

r. In s. Ins 9.31 (1) (c), insert the word "the" at the beginning of the phrase. In addition, pars. (a) to (c) should be renumbered as subs. (1) to (3).

s. In s. Ins 9.32, and in other long rule sections in ch. Ins 9 which do not currently have subsection titles, consider inserting subsection titles to guide the reader as to the subject matter of each subsection.

t. In s. Ins 9.32 (3), after the word "acknowledge," insert "to the consumer," so that it is clear who the acknowledgement is being given to.

u. In s. Ins 9.32 (4), delete "all grievances" in the second line and insert "a grievance."

v. In s. Ins 9.33 (2), the word "a" should be inserted before the second occurrence of the phrase "health maintenance organization." Also, sub. (6) (a) and (b) should be combined into one subsection. Finally, in sub. (6), a cross-reference should be included to s. 609.22 (7), Stats.

w. In s. Ins 9.34 (3), the comma should be deleted.

x. In s. Ins 9.35 (2), in the second line, delete the word "provide" and insert the word "provider."

y. In s. Ins 9.37 (5), the phrase "which ever" should be one word.

z. In s. Ins 9.39 (1) (a), the material presented should conclude with a period. Also, should sub. (2) refer to a preferred provider plan as does sub. (3)?

aa. In Appendix C, under the hold harmless provisions, Section A. 1., the acronym "IPA" is used to refer to both an individual practice association and an independent practice association. The same acronym should not be used to refer to two different entities. If they are meant to be the same entity, revise accordingly.

Chapter Ins 9

Managed Care Plans

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE REPEALING AND CREATING A RULE

To repeal Ins 3.48, Ins 3.50, and Ins 3.52; to create Ins 3.67, Ins 6.11(3)(b)4, and ch. Ins 9, Wis. Adm. Code, relating to revising requirements for managed care plans and limited service health organization plans to comply with recent changes in state laws.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41(3), 609.38, and 632.85, Stats.

Statutes interpreted: ss. Ch. 609 and 632.85, Stats.

Most of these revisions are based on new requirements for managed care plans established in 1997 Wisconsin Act 237 and 1997 Wisconsin Act 155. Some of the requirements also apply to all group or individual health plans.

The definition of a managed care plan has been expanded to meet new statutory requirements and includes most forms of group or individual health insurance that create financial incentives for policyholders to use a specified provider or group of providers.

Financial requirements for health maintenance organizations and limited service health organizations have been repealed and recreated within ch. Ins 9.

Health maintenance organizations and limited service health organizations are required to submit quality assurance plans with their business plans.

The grievance procedures for managed care plans and limited service health organizations have been expanded to meet new statutory requirements and to improve the review process.

State statutes require managed care plans to ensure enrollees have reasonable access to health care providers. This rule outlines the method by which plans assure the commissioner that reasonable access will exist.

Managed care plans are required to ensure continuing access, for a reasonable period of time, to providers who were represented to enrollees as available at the time the enrollee joined the plan if the provider leaves the plan in the middle of a plan year.

Managed care plans are specifically not permitted to create contracts with providers that interfere with a providers ability to communicate all medical treatment options to plan enrollees.

Managed care plans are required to develop quality assurance plans that are reported to the commissioner. Effective January 1, 2000, managed care plans will be required to collect and report HEDIS data to the commissioner.

Managed care plans must disclose significant policy limitations in the policy and to enrollees and must use policies that comply with all Wisconsin insurance mandates.

Disenrollment from a managed care plan is only permitted in limited circumstances.

All health benefit plans must provide enrollees with clear and timely explanations if experimental treatment is denied. All health benefit plans must also provide a process for appealing a plan decision to deny coverage of experimental treatment.

All health benefit plans must provide a process to permit an enrollee who is denied drug coverage because the drug was not on a pre-approved list or formulary maintained by the health plan an opportunity to appeal the denial.

It will be considered an unfair claims settlement practice to deny coverage of emergency room treatment based solely on the diagnosis of the patient. All health benefit plans must consider the presenting symptoms of the enrollee and use the "prudent layperson" standard to determine if treatment will be covered by the health benefit plan.

All health benefit plans must establish a compliance program incorporating procedures to verify compliance with the requirements of Ins 9.07 and Ins 9 subchapter II.

SECTION 1. Ins 3.48, Ins 3.50, Ins 3.52 are repealed.

SECTION 2. Ins 3.67 is created to read::

Ins 3.67 Benefit Appeals Under Certain Policies.

(1) DEFINITIONS. In this section:

(a) "Expedited request" means a request where the standard resolution process may include any of the following:

1. Seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function.

2. In the opinion of a health care provider with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

3. Is determined to be an expedited request by a physician with knowledge of the enrollee's medical condition.

(b) "Grievance" means any dissatisfaction with the administration, claims practices or provision of services by a managed care plan that is expressed orally or in writing by, or on behalf of, a plan enrollee to the insurer.

(c) "Health benefit plan" has the meaning provided under s. 632.745 (11), Stats.

(d) "Limited service health organization" has the meaning provided under s. 609.01(3), Stats.

(e) "Managed care plan" has the meaning provided under s. 609.01(3c), Stats.

(2) DRUGS AND DEVICES. (a) An insurer offering a health benefit plan that uses a drug formulary or any list of prior approved pharmaceuticals shall have an internal procedure that permits enrollees, or the enrollee's representative, to request coverage of items not on the approved list.

(b) Any requests for items under this section shall be treated by a managed care plan as a grievance.

(3) COVERAGE OF EXPERIMENTAL TREATMENTS. (a) Any coverage limitations for experimental treatment shall be clearly disclosed in every policy issued by a health care plan.

(b) A health care plan or self-insured plan that limits coverage for experimental treatment shall have an internal procedure consistent with s. 632.855, Stats., including issuing a written coverage decision within 5 business days of receipt of the request.

(c) Any appeal of benefits denied as experimental treatment, shall be treated as a grievance on the managed care plan annual grievance report to the commissioner.

(4) APPEAL PROCEDURE. The procedure established under this section shall include all of the following:

(a) The opportunity for the policyholder or certificate holder, or a representative of the policyholder or certificate holder, to submit a written request, which may

be in any form and which may include supporting material, for review by the insurer of the denial of any benefits under the policy.

(b) The health care plan or self-insured plan shall acknowledge, in writing, a request for review of coverage under sub. (2), within 5 business days of receiving it.

(c) Within 30 calendar days after receiving the request under sub. (2) or (3), the health care plan or self-insured plan shall provide the disposition of the review and notify the person who submitted the request for review of the results of the review.

(d) A process to resolve an expedited request for review as expeditiously as the health condition requires but not to exceed 72 hours from the receipt of a substantially completed request under sub. (2) or (3).

(e) An insurer shall describe the procedure established under this subsection in every policy, group certificate and outline of coverage issued in connection with a health benefit plan.

(f) If an insurer denies any benefit under sub. (2) or (3), the insurer shall, at the time the insurer gives notice of the denial of benefits, provide the policyholder with a written description of the appeal process.

(g) Each insurer offering a health benefit plan shall keep together, at its home or principal office, all records of appeals under this paragraph. The insurer shall make these records available for review during examinations or at the request of the commissioner.

SECTION 3. Ins 6.11(3)(b)4 is created to read:

Ins 6.11(3)(b)4 Refusing payment of a claim under a disability policy for emergency room treatment that is not consistent with s. 632.85, Stats.

SECTION 4. Ch. Ins 9 is created to read:

CHAPTER INS 9

Managed Care Plans

Ins 9.01 Definitions. In addition to the definitions in s. 609.01, Stats., in this chapter:

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

(2) "Complaint" means any dissatisfaction about an insurer or its contracted providers expressed in writing by an enrollee, or an enrollee's representative, to the commissioner.

(3) "Expedited grievance" means a grievance where the standard resolution process may include any of the following:

(a) Seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function.

(b) In the opinion of a physician with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.

(c) It is determined to be an expedited grievance by a physician with knowledge of the enrollee's medical condition.

(4) "Grievance" means any dissatisfaction with the administration, claims practices or provision of services by a managed care plan that is expressed orally or in writing by, or on behalf of, a plan enrollee to the insurer.

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

(6) "Hospital emergency facility" means any hospital facility that offers services for emergency medical conditions as described in s. 632.85(1)(a), Stats., within its capability to do so and in accordance with HFS 124.24, or the licensure requirements of the jurisdiction in which the hospital resides.

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

(8) "Managed care plan" has the meaning provided under s. 609.01(3c), Stats.

Subchapter I: Health Maintenance Organizations and Limited Service Health Organizations.

Ins 9.02 Purpose. This subchapter establishes financial standards for health maintenance organizations and limited service health organizations doing business in Wisconsin. These requirements are in addition to any other statutory or administrative rule requirements which apply to health maintenance organizations and limited service health organizations.

Ins 9.03 Scope. This subchapter applies to all insurers writing health maintenance organization or limited service health organization business in this state.

Ins 9.04 Financial requirements. The following are the minimum financial requirements for compliance with this section unless a different amount is ordered by the commissioner.

(1) CAPITAL. Unless otherwise ordered by the commissioner the minimum capital or permanent surplus of:

(a) A health maintenance organization insurer first licensed or organized on or after July 1, 1989, is $750,000;

(b) A health maintenance organization insurer first licensed or organized prior to July 1, 1989, is $200,000;

(c) The minimum capital or permanent surplus requirement for an insurer licensed to write only limited service health organization business shall be not less than $75,000.

(d) The commissioner may accept the deposit or letter of credit under sub. (3) to satisfy the minimum capital or permanent surplus requirement under par. (1)(c), if the insurer licensed to write only limited service health organization business demonstrates to the satisfaction of the commissioner that it does not retain any risk of financial loss because all risk of loss has been transferred to providers through provider agreements.

(e) Any other insurer writing health maintenance organization or limited service health organization business, is the amount of capital or required surplus required under the statutes governing the organization of the insurer.

(2) COMPULSORY SURPLUS. (a) An insurer, including an insurer organized under ch. 613, Stats., writing health maintenance organization or limited service health organization business, except for a health maintenance organization insurer or an insurer licensed to write only limited service health organization business, is subject to s. Ins 51.80. A health maintenance organization insurer shall maintain compulsory surplus as follows, or a greater amount required by order of the commissioner: the greater of $750,000 or an amount equal to the sum of:

1. 10% of premiums earned in the previous 12 months for policies which include coverages which are other insurance business under s. 609.03(3)(a)3., Stats.; plus

2. 3% of other premium earned in the previous 12 months except that if the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is less than 90%, 6% of other premiums earned in the previous 12 months.

(b) Each insurer licensed to write only limited service health organization business shall maintain a compulsory surplus to provide security against contingencies that affect its financial position but which are not fully covered by provider contracts, insolvency insurance, reinsurance, or other forms of financial guarantees. The compulsory surplus is the greater of 3% of the premiums earned by the limited service health organization in the previous 12 months; or $75,000.

(c) The commissioner may accept a deposit or letter of credit with the same terms and conditions as required under sub. (3) to satisfy the compulsory surplus requirement if the limited service health organization demonstrates to the satisfaction of the commissioner that it does not retain any risk of financial loss because all risk of loss has been transferred to providers through provider agreements. The commissioner may, by order, require a higher or lower compulsory surplus or may establish additional factors for determining the amount of compulsory surplus required for a particular limited service health organization.

(3) DEPOSIT OR LETTER OF CREDIT. Each limited service health organization shall maintain either a deposit of securities with the state treasurer or an acceptable letter of credit on file with the commissioner's office. The amount of the deposit or letter of credit shall be not less than $75,000 for limited service health organizations. The letter of credit shall be payable to the commissioner whenever rehabilitation or liquidation proceedings are initiated against the limited service health organization.

(4) RISKS. Risks and factors the commissioner may consider in determining whether to require greater compulsory surplus by order include, but are not limited to, those described under s. 623.11(1)(a) and (b), Stats., and the extent to which the insurer effectively transfers risk to providers. A health maintenance organization insurer may transfer risk through any mechanism including, but not limited to, those provided under s. Ins 9.05(4).

(5) SECURITY SURPLUS. (a) An insurer, including an insurer organized under ch. 613, Stats., writing health maintenance organization insurance or limited service health organization business, except for a health maintenance organization insurer or an insurer licensed to write only limited service health organization business, is subject to s. Ins 51.80. Health maintenance organization insurers and insurers licensed to write only limited service health organization business should maintain a security surplus to provide an ample margin of safety and clearly assure a sound operation. The security surplus of a health maintenance organization insurer shall be the greater of:

1. Compulsory surplus plus 40% reduced by 1% for each $33 million of premium in excess of $10 million earned in the previous 12 months; or

2. 110% of its compulsory surplus.

(b) The security surplus of an insurer licensed to write only limited service health organization business shall be ~~equal to~~ not less than 110% of compulsory surplus.

(6) INSOLVENCY PROTECTION FOR POLICYHOLDERS. (a) Each health maintenance organization insurer is required to either maintain compulsory surplus as required for other insurers under s. Ins 51.80 or to demonstrate that in the event of insolvency all of the following shall be met:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged.

2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or pre-existing limitation requirements.

(b) Each insurer licensed to write only limited service health organization business which provides hospital benefits shall demonstrate that, in the event of an insolvency, enrollees hospitalized at the time of an insolvency will be covered until discharged.

Ins 9.05 Business plan. All applications for certificates of incorporation and certificates of authority of a health maintenance organization insurer or an insurer licensed to write only limited service health organization business shall include a proposed business plan. In addition to the items listed in s. 611.13(2) and 613.13(1), Stats., the following information shall be contained in the business plan:

(1) ORGANIZATION TYPE. (a) The type of health maintenance organization insurer, including whether the providers affiliated with the organization will be salaried employes or group or individual contractors, or

(b) 1. The name and address of the insurer licensed to write only limited service health organization business and the names and addresses of individual providers, if any, who control the insurer licensed to write only limited service health organization business, and;

2. The type of organization, including information on whether providers will be salaried employes of the organization or individual or group contractors.

(2) FEASIBILITY STUDIES AND MARKETING SURVEYS. A summary of feasibility studies or marketing surveys which support the financial and enrollment projections for the health maintenance organization insurer or the insurer licensed to write only limited service health organization business. The summary shall include the potential number of enrollees in the operating territory, the projected number of enrollees for the first 5 years, the underwriting standards to be applied, and the method of marketing the organization.

(3) GEOGRAPHICAL SERVICE AREA. The geographical service area by county including a chart showing the number of primary and specialty care providers with locations and service areas by county; the method of handling emergency care, with locations of emergency care facilities; and the method of handling out–of–area services.

(4) PROVIDER AGREEMENTS. The extent to which any of the following will be included in provider agreements and the form of any provisions which do any of the following:

(a) Limit the providers' ability to seek reimbursement for covered services from policyholders or enrollees.

(b) Permit or require the provider to assume a financial risk in the health maintenance organization insurer, including any provisions for assessing the

provider, adjusting capitation or fee–for–service rates, or sharing in the gs or losses.

(c) Govern amending or terminating agreements with providers.

(5) PROVIDER AVAILABILITY. A description of how services will be provided to policyholders in each service area including the extent to which primary care will be given by providers under contract to the health maintenance organization insurer.

(6) QUALITY ASSURANCE. A summary of comprehensive quality assurance standards that identify, evaluate and remedy problems related to access to care and continuity and quality of care. The summary shall address all of the following:

(a) A written internal quality assurance program.

(b) Written guidelines for quality of care studies and monitoring.

(c) Performance and clinical outcomes–based criteria.

(d) Procedures for remedial action to address quality problems, including written procedures for taking appropriate corrective action.

(e) Plans for gathering and assessing data.

(f) A peer review process.

(g) A process to inform enrollees on the results of the insurer's quality assurance program.

(h) Any additional information requested by the commissioner.

(7) PLAN ADMINISTRATION. A summary of how administrative services will be provided, including the size and qualifications of the administrative staff and the projected cost of administration in relation to premium income. If management authority for a major corporate function is delegated to a person outside the organization, the business plan shall include a copy of the contract. The contract shall include the services to be provided, the standards of performance for the manager, the method of payment including any provisions for the administrator to participate in the profit or losses of the plan, the duration of the contract and any provisions for modifying, terminating or renewing the contract. Contracts for delegated management authority shall be filed for approval with the commissioner under ss. 611.67 and 618.22, Stats.

(8) FINANCIAL PROJECTIONS. A summary of current and projected enrollment, income from premiums by type of payor, other income, administrative and other costs, the projected break even point, including the method of funding the accumulated losses until the break even point is reached, and a summary of the assumptions made in developing projected operating results.

(9) FINANCIAL GUARANTEES. A summary of all financial guarantees by providers, sponsors, affiliates or parents within a holding company system, or any other

guarantees which are intended to ensure the financial success of the health maintenance organization insurer. These include hold harmless agreements by providers, insolvency insurance, reinsurance or other guarantees.

(10) CONTRACTS WITH ENROLLEES. A summary of benefits to be offered enrollees including any limitations and exclusions and the renewability of all contracts to be written.

Ins 9.06 Changes in the business plan. A health maintenance organization insurer or an insurer licensed to write only limited service health organization business shall file a written report of any proposed substantial change in its business plan. The insurer shall file the report at least 30 days prior to the effective date of the change. The office may disapprove the change. The insurer may not enter into any transaction, contract, amendment to a transaction or contract or take action or make any omission which is a substantial change in the insurer's business plan prior to the effective date of the change or if the change is disapproved. Substantial changes include changes in articles and bylaws, organization type, geographical service areas, provider agreements, provider availability, plan administration, financial projections and guarantees and any other change which might affect the financial solvency of the plan. Any changes in the items listed in Ins. 9.05(4) shall be filed under this section.

Ins 9.07 Copies of provider agreements. (1) All managed care plans and limited service health organization insurers shall maintain executed copies of any provider agreements arising out of the contract between the insurer and the managed care plan, including those with providers and subcontracts with individual practice associations or individual providers, in the insurer's administrative office and shall be made available to the commissioner on request.

(2) All health maintenance organization insurers or insurers licensed to write only limited service health organization business shall file with the commissioner, prior to doing business, copies of all executed provider agreements and other contracts covering liabilities of the health maintenance organization. For contracts with providers, a list of providers executing a standard contract and a copy of the form of the contract may be filed instead of copies of the executed contracts.

Ins 9.08 Other reporting requirements.

(1) All insurers authorized to write health maintenance organization business and insurers licensed to write only limited service health organization business shall file with the commissioner by March 1 of each year an annual statement for the preceding year. A health maintenance organization insurer shall use the current Health Maintenance Organization annual statement blank prepared by the national association of insurance commissioners.

(a) A health maintenance organization insurer shall include with its annual statement a statement of covered expenses, and a special procedures opinion from a certified public accountant, in the form prescribed by the commissioner as Appendix A.

(b) A health maintenance organization insurer shall file a quarterly report, including a report concerning covered expenses, in a form prescribed by the commissioner, within 45 days after the close of each of the first 3 calendar quarters of the year unless the commissioner has notified the insurer that another reporting schedule is appropriate.

(c) A health maintenance organization insurer shall include with its annual audit financial reports filed under Ins 16.02 a statement of covered expenses and an audit opinion concerning the statement. Both the statement and opinion shall be in the form prescribed by the commissioner as Appendix B and are due no later than May 1 of each year.

(2) An insurer writing health maintenance organization business, other than a health maintenance organization insurer, shall file a quarterly report in a form prescribed by the commissioner within 45 days after the close of each of the first 3 calendar quarters of the year unless the commissioner notifies the insurer that another reporting schedule is appropriate.

(3) (a) If a health maintenance organization insurer fails to file a statement or opinion required under sub. (1) to (3) by the time required, it is presumed, in any action brought by the office within one year of the due date, that the health maintenance organization insurer is in financially hazardous condition and that the percentage of its liabilities for health care costs which are covered liabilities is and continues to be less than 65% for the purpose of s. 609.95, Stats.

(b) It is presumed that the percentage of liabilities which are covered liabilities of a health maintenance organization insurer is and continues to be not greater than the percentage of covered expenses stated in the report or statement filed under sub. (1) to (4) for the most recent period.

(c) The health maintenance organization insurer has the burden of refuting a presumption under par. (a) or (b).

(4) An insurer licensed to write only limited service health organization business shall use the current Limited Service Health Organization annual statement blank prepared by the national association of insurance commissioners.

(5) All other insurers shall file an annual report in a form prescribed by the commissioner.

Ins 9.09 Notice of election and termination of hold harmless.

(1) A notice of election to be exempt from s. 609.91(1)(b), Stats., or a notice of termination of election to be subject to s. 609.91(1)(c), Stats., in accord with s. 609.925(1), Stats., is effective only if filed on the form prescribed by the commissioner and if the form is properly completed.

(2) A notice of termination of election to be exempt from s. 609.91(1)(b), Stats., in accord with s. 609.92(4), Stats., or a notice of termination of election to be subject to s. 609.91(1)(c), Stats., in accord with s. 609.925(2), Stats., shall be filed on the form

prescribed by the commissioner. Notices described in this subsection that are filed with the commissioner but are not on the prescribed form or are not properly completed are nevertheless effective.

(3) In accordance with s. 609.93, Stats., a provider may not exercise an election under s. 609.92, or 609.925, Stats., separately from a clinic or 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 or provided through the clinic.

Ins 9.10 Receivables from affiliates. A receivable, note or other obligation of an affiliate to a health maintenance organization insurer and limited service health organization insurer shall be valued at zero by the insurer for all purposes including, but not limited to, for the purpose of reports or statements filed with the office, unless the commissioner specifically approves a different value. The different value shall be not more than the amount of the receivable, note or other obligation which is fully secured by a security interest in cash or cash equivalents held in a segregated account or trust.

Ins 9.11 Receivables from IPA. After December 31, 1990, a health maintenance organization insurer shall value receivables, notes or obligations of individual practice associations as defined under s. 600.03(23g), Stats., at zero for all purposes including, but not limited to, for the purpose of reports or statements filed with the office, unless the receivable, note or obligation is fully secured by a security interest in cash or cash equivalents held in a segregated account or trust.

Ins 9.12 Incidental or immaterial indemnity business in health maintenance organizations. (1) Except as provided by sub. (2), insurance business is not incidental or immaterial under s. 609.03(3)(a)3, Stats., if a health maintenance organization insurer issues coverage which is not typically included in a health maintenance organization or limited service health organization policy and the insurer does any of the following:

(a) Markets the policy containing the coverage.

(b) The total premium for policies containing the coverage exceeds or is projected to exceed 5% of total premium earned in any 12-month period.

(2) Insurance business is incidental or immaterial under s. 609.03(3)(a)3, Stats., if the business is written according to the terms of a specific business plan for issuance of coverage under s. 609.03(3)(a)3, Stats., and the business plan is approved in writing by the office. A request for approval to do business under this paragraph including, but not limited to, issuance of policies with point of service coverage, shall include a detailed business plan, a copy of the policy form, a detailed description of how the business will be marketed and premium volume controlled, and other information prescribed by the office. The total premium for policies containing coverages subject to this paragraph and policies issued under sub. (1) may not exceed 10% of premium earned or projected to be earned in any 12-month period.

(3) If the commissioner approves insurance business as incidental or immaterial the commissioner may also, by order under Ins 9.04(2), require the insurer to maintain more than the minimum compulsory surplus.

(4) For the purpose of this section, any coverage which covers services by a provider other than a participating provider is not typically included in a health maintenance organization or limited service health organization policy, except coverage of emergency out–of–area services.

Ins 9.13 Summary. A health maintenance organization insurer shall use the form prescribed in Appendix C to comply with s. 609.94, Stats.

Ins 9.14 Nondomestic HMO. No certificate of authority may be issued under ch. 618, Stats., on or after September 1, 1990, to a person to do health maintenance organization or limited service health organization business in this state unless the person is organized and regulated as an insurer and domiciled in the United States. Any person issued a certificate of authority under ch. 618, Stats., to do health maintenance organization business prior to the effective date of this rule which is not organized and regulated as an insurer and domiciled in the United States shall cease doing business in this state not later than January 1, 1993.

Ins 9.15 Time period. In accordance with s. 227.116, Stats., the commissioner shall review and make a determination on an application for a certificate of authority within 60 business days after it has been received.

Subchapter II: Market Conduct Standards for Managed Care Plans

Ins 9.30 Purpose. This subchapter establishes market conduct standards for insurers offering managed care plans, and limited service health organizations doing business in Wisconsin. These requirements are in addition to any other statutory or administrative rule requirements that apply to these managed care plans.

Ins 9.31 Scope. This subchapter applies to all insurers providing managed care plans or limited service health organization plans in this state. The insurer shall ensure that the requirements of this subchapter are met by all managed care plans or limited service health organization plans issued by the insurer. The commissioner may approve an exemption to this subchapter for an insurer to market a health benefit plan or limited service health organization plan if the plan is filed with the commissioner and the commissioner determines that all of the following conditions are met:

(a) The coverage involves minimal cost controls, such as minimal cost controls involving vision, prescription cards or transplant centers.

(b) The cost controls are unlikely to significantly affect the pattern of practice.

(c) Exemption is consistent with the purpose of this subchapter.

Ins 9.32 Grievance procedure.

(1) Each managed care plan and limited service health organization plan shall incorporate within its policies and certificates a definition of a grievance. The managed care plan or limited service health organization shall develop an internal grievance procedure which shall be described in each policy and certificate issued to enrollees at the time of enrollment or issuance. In accord with s. 609.15(1a), Stats., managed care plans and limited service health organization plan shall investigate each grievance.

(2) In addition to the notice requirement under sub. (1), each time the managed care plan or limited service health organization plan denies a claim or benefit, including a refusal to refer an enrollee, or initiates disenrollment proceedings, the managed care plan or limited service health organization plan shall notify the affected enrollee of the right to file a grievance and the procedure to follow. The notification shall state the specific reason for the denial or initiation.

(3) The managed care plan or limited service health organization plan shall acknowledge, in writing, a grievance within 5 business days of receiving it.

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

(5) A grievance procedure shall include a method whereby the enrollee who filed the grievance, or the enrollee's representative, has the right to appear in person before the grievance panel to present written or oral information and may question those people responsible for making the determination which resulted in the grievance. The managed care plan or limited service health organization plan shall inform the enrollee, in writing, of the time and place of the meeting at least 7 calendar days before the meeting. Managed care plans and limited service health organization plans shall provide reasonable accommodations to allow the enrollee who filed the grievance, or the enrollee's representative, to participate in the meeting.

(6) Subs. (3) to (5) do not apply to situations where the normal grievance resolution process could have adverse health effects for the enrollee. For these situations, managed care plans and limited service health organization plans shall develop a separate expedited grievance procedure for expedited grievance situations and inform the enrollees of this procedure at the time of enrollment. This procedure shall require a managed care plan or limited service health organization plan to resolve an expedited grievance as expeditiously as the enrollee's health condition requires but within 72 hours of receipt of a written or oral grievance.

(7) Managed care plans and limited service health organization plans shall record, retain, and report records for each complaint and grievance in accordance with all of the following requirements:

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

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

(c) Each managed care plan or limited service health organization plan shall submit a grievance experience report required by s. 609.15(1)(c), Stats., to the commissioner by March 1 of each year. The report shall provide information on all grievances received during the previous calendar year. The report shall be in a form prescribed by the commissioner and, at a minimum, shall classify grievances into the following categories:

1. Plan administration including plan marketing, policyholder service, billing, underwriting, or similar administrative functions.

2. Benefit denials including denial of a benefit, refusal to refer enrollees or to provide requested services.

3. Quality of care, including health care outcomes.

(d) Each insurer offering a managed care plan or limited service health organization plan shall maintain, at its home or principal office, all records on complaints and grievances. The insurer shall make these records available for review during examinations by or on request of the commissioner.

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

Note: A copy of the grievance experience report form required under par. (7)(c), OCI26-007, may be obtained from the Office of the Commissioner of Insurance, P. O. Box 7873, Madison WI 53707-7873.

Ins 9.33 Access standards.

(1) An insurer offering a managed care plan shall submit an annual certification to the commissioner no later than August 1 of each year demonstrating compliance with the access standards of this section and with s. 609.22, Stats. The certification shall be submitted on a form prescribed by the commissioner and signed by an officer of the company.

(2) An insurer offering a health maintenance organization plan, or an insurer offering a managed care plan other than health maintenance organization insuring more than 2,500 Wisconsin enrollees, shall file a report along with the annual certification on the numbers and types of providers available in the plan. The report shall be on a form designated by the commissioner and shall demonstrate all the following:

(a) Services can be provided by plan providers with reasonable promptness with respect to geographic location, hours of operation, waiting times for appointments in provider offices and after hours care. The hours of operation, waiting times, and availability of after hours care shall reflect the usual practice in the local area. Geographic availability shall reflect the usual medical travel times within the community.

(b) The number and type of plan providers, as well as the number of primary providers accepting new patients is sufficient with respect to current and expected enrollees to adequately deliver all covered services based on the demographics and health status of enrollees served by the plan.

(c) There exist written agreements with plan providers describing their specific responsibilities with respect to the access standards in this section.

(d) Emergency care is available 24 hours per day and 7 days per week.

(3) The report submitted to the commissioner shall include certification and licensure status of providers under contract with the plan, including the written criteria for selection, retention and removal of network providers.

(4) The report shall also identify enrollees who are members of underserved populations, or who have language or cultural barriers to obtaining health care and how the plan meets the needs of those enrollees.

(5) Managed care plans that permit enrollees to use non-plan providers shall also include an analysis of the frequency and provider types for use of non-network providers.

(6) Managed care plans shall provide telephone access for its enrollees and providers participating in the plan.

(a) Each insurer offering a managed care plan shall maintain a nationwide toll-free number for the use of enrollees and providers participating in the plan.

(b) An insurer who contracts with a preferred provider plan or an individual practice association shall ensure that all providers meet the requirements of this subsection.

Ins 9.34 Continuity of care.

(1) Upon termination of any provider from a managed care plan, the plan shall notify all affected enrollees of the termination and each enrollee's options for receiving continued care from the terminated provider not later than 30 days prior to the

termination. A managed care plan shall provide information on substitute providers to all affected enrollees.

(2) A managed care plan is not required to provide continued coverage for services of a provider if the provider no longer practices in the managed care plan's geographic service area or the insurer issuing the managed care plan terminates the provider's contract due to professional misconduct on the part of the provider.

(3) Managed care plans shall make available to the commissioner upon request, any information needed to establish cause for termination of providers.

Ins 9.35 Gag clauses.

(1) Any contract between a managed care plan and a participating provider may not limit the provider's ability to disclose information, to or on behalf of an enrollee, about the enrollee's medical condition.

(2) A participating provider may discuss, with or on behalf of an enrollee, all treatment options and any other information that the provide determines to be in the best interest of the enrollee and within the scope of the provider's professional license. A managed care plan may not penalize the participating provider nor terminate the contract of a participating provider because the provider makes referrals to other participating providers or discusses medically necessary or appropriate care with or on behalf of an enrollee.

Ins 9.36 Notice requirements.

(1) Prior to enrolling members, the managed care plan shall provide to prospective group or individual policyholders, certificate holders, or enrollees information on the plan, including services covered, a definition of emergency and out-of-area coverage, the cost of the plan, enrollment procedures, and limitations on benefits including limitations on choice of providers and the geographical area serviced by the organization.

(2) Managed care plans shall make current provider directories available to enrollees upon enrollment, and no less than annually, following the first year of enrollment.

(3) Managed care plans that permit obstetricians or gynecologists to serve as primary providers shall clearly state so in enrollment materials. Managed care plans that limit access to obstetricians and gynecologists shall clearly state in enrollment materials the process for obtaining referrals.

(4) Managed care plans shall make information available to their enrollees describing the criteria for obtaining a standing referral to a specialist, including diagnoses, frequency of visits, or other conditions. Plans may require periodic re-referral, but, in no instance, more frequently than annually for any individual specialist.

Ins 9.37 Policy and certificate language requirements. Each policy form marketed by a managed care organization and each certificate issued to enrollees shall contain all of the following:

(1) A definition of geographical service area, emergency care, urgent care, out-of-area services, dependents and primary provider, if these terms or terms of similar meaning are used in the policy or certificate and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the policy or certificate if such definition is adequately described in an attachment which is given to all enrollees along with the policy or certificate.

(2) Clear disclosure of any provision which limits benefits or access to service in the exclusions, limitations, and exceptions sections of the policy or certificate. Among the exclusions, limitations and exceptions which shall be disclosed are those relating to emergency and urgent care, restrictions on the selection of primary or referral providers, restrictions on changing providers during the contract period, out-of-pocket costs including copayments and deductibles, and any restrictions on coverage for dependents who do not reside in the service area.

(3) Clear disclosure of all benefit mandates outlined in Wisconsin statutes.

(4) A description of the procedure for any enrollee to obtain a second opinion from a participating plan provider consistent with s. 609.22(5), Stats.

(5) Authorization for access to emergency care consistent with s. 609.22(6), Stats. A plan may require enrollees to notify the insurer of emergency room usage, but in no case may the insurer require notification less than 48 hours after receiving services or before it is medically feasible for the enrollee to provide the notice, which ever is later. An insurer may impose a deductible not to exceed the lesser of 50% of covered expenses for emergency treatment or $250.00 for failing to comply with emergency treatment notification requirements.

Ins 9.38 Disenrollment.

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

(2) Except as provided in s. 632.897, Stats., the health maintenance organization or limited service health organization may only disenroll an enrollee if one of the following occurs:

(a) The enrollee has failed to pay required premiums by the end of the grace period.

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

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

(d) The enrollee has moved outside of the geographical service area of the organization.

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

(3) Notwithstanding sub. (2), the health maintenance organization or limited service health organization plan may not disenroll an enrollee for reasons related to the physical or mental condition of the enrollee, failure of the enrollee to follow a prescribed course of treatment or for administrative actions on the part of the insurer such as failure to keep an appointment.

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

Ins 9.39 Required quality assurance plans.

(1) In this section:

(a) "HEDIS data" means the Health Plan Employer Data and Information Set as defined by the National Committee on Quality Assurance

(b) "Quality assurance" means the measurement and evaluation of the quality and outcomes of medical care provided.

(2) No later than April 1 of each year, every managed care plan and limited service health organization shall submit a quality assurance plan consistent with the requirements of s. 609.32, Stats., to the commissioner. The plan shall be designed to reasonably assure that health care services provided to enrollees of managed care plans meet the quality of care consistent with prevailing standards of medical practice in the community. The quality assurance plan shall document the procedures used to train employees of the managed care plan in the content of the quality assurance plan.

(3) Beginning April 1, 2001, every managed care plan, limited service health organization and preferred provider plan shall submit its HEDIS data, or other standardized data set designated by the commissioner, for the previous calendar year to the commissioner no later than April 1 of each year. No later than July 1 of each year, the commissioner shall prepare a summary report on the collected data.

9.41 Compliance program requirements. (1) All managed care plans and limited service health organization insurers shall establish a compliance program and procedures to verify compliance with this subchapter and Ins. 9.07.

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Ins 9 Appendix A

AUDITOR'S SPECIAL PROCEDURES REPORT ON THE SCHEDULE OF COVERED EXPENSES

Board of Directors

XYZ HMO

We have performed the following special procedures with respect to the Schedule of Covered Expenses for XYZ HMO for the year ended December 31, XXXX. It is understood that this report is solely to assist you in complying with ch. Ins 9, Wis. Adm. Code, and ch. 609, Wis. Stats., and our report is not to be used for any other purpose. Our procedures and findings are as follows:

a. A randomly selected sample was taken from all medical and hospital expenses paid during the calendar year to test the attribute that the expenses reported on the provider's IRS 1099-MISC forms (or other supporting documentation for providers not issued an IRS-1099-MISC form) trace to the Schedule of Covered Expenses for those providers included on the Schedule of Covered Expenses.

b. A comparison was made between the Schedule of Covered Expenses and the Election of Exemption notices by providers to verify that providers which had given notice of their Election of Exemption prior to December 31, XXXX, and which had not also given notice of their Termination of Election prior to December 31, XXXX, are excluded from the Schedule of Covered Expenses.

c. A review of the assumptions and methods of the HMO in establishing the amount of covered expenses included in the Incurred But Not Reported line of the Schedule of Covered Expenses was undertaken to determine if the company's estimate is reasonably estimated based on the HMO's historical data and best information available to the HMO.

Because the procedures do not constitute an examination made in accordance with generally accepted auditing standards, we do not express an opinion on any of the accounts or items referred to above. The following summarizes our findings as a result of the procedures referred to above.

FINDINGS REPORTED HERE

Had we performed any additional procedures, other matters might have come to our attention that would have been reported to you. This report relates only to the items specified above and does not extend to any financial statements of the HMO taken as a whole.

Date	CPA Signature

Ins 9 Appendix B

AUDITOR'S REPORT ON THE SCHEDULE OF COVERED EXPENSES

Date

BOARD OF DIRECTORS

XYZ Health Maintenance Organization

We have audited, in accordance with generally accepted auditing standards, Financial Statements of XYZ Health Maintenance Organization for the year ended December 31, XXXX, and have issued our report thereon dated XXXXXXXXXX XX, XXXX. We have also audited the accompanying Schedule of Covered Expenses for XYZ Health Maintenance Organization as of December 31, XXXX. This schedule is the responsibility of management of XYZ Health Maintenance Organization. Our responsibility is to express an opinion on this schedule based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the aforementioned schedule is free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the aforementioned schedule. An audit also includes assessing the accounting principles used and any significant estimates made by management, as well as evaluating the overall schedule presentations. We believe that our audit provides reasonable basis for our opinion.

In our opinion, the schedule referred to above presents fairly, in all material respects, covered expenses for the year ended December 31, XXXX

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CPA Signature

Ins 9 Appendix C

NOTICE

THIS NOTICE DESCRIBES HOLD-HARMLESS PROVISIONS WHICH AFFECT YOUR ABILITY TO SEEK RECOURSE AGAINST HMO ENROLLEES FOR PAYMENT FOR SERVICES

Section 609.94, Wis. Stat., requires each health maintenance organization insurer (HMO) to provide a summary notice to all of its participating providers of the statutory limitations and requirements in §§ 609.91 to 609.935, and § 609.97 (1), Wis. Stat.

SUMMARY

Under Wisconsin law a health care provider may not hold HMO enrollees or policyholders ("enrollees") liable for costs covered under an HMO policy if the provider is subject to statutory provisions which "hold harmless" the enrollees. For most health care providers application of the statutory hold-harmless is "mandatory" or it applies unless the provider elects to "opt-out." A provider permitted to "opt-out" must file timely notice with the Wisconsin Office of the Commissioner of Insurance ("OCI").

Some types of provider care are subject to the statutes only if the provider voluntarily "opts-in." An HMO may partially satisfy its regulatory capital and surplus requirements if health care providers elect to remain subject to the statutory hold-harmless provisions.

This notice is only a summary of the law. Every effort has been made to accurately describe the law. However, if this summary is inconsistent with a provision of the law or incomplete, the law will control.

Filings for exemption with OCI must be on the prescribed form to be effective.

HOLD HARMLESS

A health care provider who is subject to the statutory hold-harmless provisions is prohibited from seeking to recover health care costs from an enrollee. The provider may not 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 enrollee or any person acting on the enrollee's behalf, for health care costs for which the enrollee is not liable. The prohibition on recovery does not effect the liability of an enrollee for any deductibles or copayments, or for premiums owed under the policy or certificate issued by the HMO.

A. MANDATORY FOR HOLD HARMLESS. An enrollee of an HMO is not liable to a health care provider for health care costs which are covered under a policy issued by that HMO if:

1. Care is provided by a provider who is an affiliate of the HMO, owns at least 5% of the voting securities of the HMO, is directly or indirectly involved with the HMO through direct or indirect selection of or representation by one or more board members, or is an Individual Practice Association ("IPA") and is represented, or an affiliate is represented, by one of at least three HMO board members who directly or indirectly represent one or more Independent Practice Associations ("IPAs") or affiliates of IPAs; or,

2. Care is provided by a provider under a contract with or through membership in an organization identified in 1.; or

3. To the extent the charge exceeds the amount the HMO has contractually agreed to pay the provider for that health care service; or

4. The care is provided to an enrolled medical assistance recipient under a Department of Health and Family Services prepaid health care policy.

B. "OPT-OUT" HOLD HARMLESS.

If the conditions described in A do not apply, the provider will be subject to the statutory hold harmless unless the provider files timely election with OCI to be exempt if the health care is:

1. Provided by a hospital or an IPA; or

2. A physician service, or other provider services, equipment, supplies or drugs that are ancillary or incidental to such services and are provided under a contract with the HMO or are provided by a provider selected by the HMO; or

3. Provided by a provider, other than a hospital, under a contract with or through membership in an IPA that has not elected to be exempt. Note that only the IPA may file election to exempt care provided by its member providers from the statutory hold harmless. (See Exemptions and Elections, No.4.)

C. "OPT-IN" HOLD HARMLESS.

If a provider of health care is not subject to the conditions described in A or B, the provider may elect to be subject to the statutory hold-harmless provisions by filing a notification with OCI stating that the provider elects to be subject with respect to any specific HMO. A provider may terminate such a notice of election by stating the termination date in that notice or in a separate notification.

CONDITIONS NOT AFFECTING IMMUNITY

An enrollee's immunity under the statutory hold harmless is not affected by any of the following:

1. Any agreement entered into by a provider, an HMO, or any other person, whether oral or written, purporting to hold the enrollee liable for costs (except a notice of election or termination permitted under the statute);

2. A breach of or default on any agreement by the HMO, an IPA, or any other person to compensate the provider for health care costs for which the enrollee is not liable.
3. The insolvency of the HNO or any person contracting with the HMO, or the commencement of insolvency, delinquency or bankruptcy proceedings involving the HMO or other persons which would affect compensation for health care costs for which an enrollee is not liable under the statutory hold harmless;
4. The inability of the provider or other person who is owed compensation to obtain compensation for health care costs for which the enrollee is not liable;
5. Failure by the HMO to provide notice to providers of the statutory hold-harmless provisions; or
6. Any other conditions or agreement existing at any time.

EXEMPTIONS AND ELECTIONS

Hospitals, IPAs, and providers of physician services who may "opt-out" may elect to be exempt from the statutory hold harmless and prohibition on recovery of health care costs under the following conditions and with the following notifications:

1. If the hospital, IPA, or other provider has a written contract with the HMO, the provider must within thirty (30) days after entering into that contract provide a notice to OCI of the provider's election to be exempt from the statutory hold-harmless and recovery limitations for care under the contract.
2. If the hospital, IPA, or other provider does not have a contract with an HMO, the provider must notify OCI that it intends to be exempt with respect to a specific HMO and must provide that notice for the period January 1, 1990, to December 21, 1990, at least sixty (60) day before the health care costs are incurred; and must provide that notice for health care costs incurred on and after January 1, 1991, at least 90 days in advance.
3. A provider who submits a notice of election to be exempt may terminate that election by stating a termination date in the notice or by submitting a separate termination notice to OCI.
4. The election by an IPA to be exempt from the statutory provisions, or the failure of an IPA to so elect, applies to costs of health care provided by any provider, other than a hospital, under contract with or through membership in the IPA. Such a provider, other than a hospital, may not exercise an election separately from the IPA. Similarly, an election by a clinic to be exempt from the statutory limitations and restrictions or the failure of the clinic to elect to be exempt applies to costs of health care provided by any provider through the clinic. An individual provider may not exercise an election to be exempt separate form the clinic.
5. The statutory hold-harmless "opt-out" provision applies to physician services only if the services are provided under a contract with the HMO or if the physician is a selected provider for the HMO, unless the services are provided by a physician for a hospital, IPA or clinic which is subject to the statutory hold-harmless "opt-out" provision.

NOTICES

All notices of election and termination must be in writing and in accordance with rules promulgated by the Commissioner of Insurance. All notices of election or termination filed with OCI are not affected by the renaming, reorganization, merger, consolidation or change in control of the provider, HMO, or other person. However, OCI may promulgate rules requiring an informational filing if any of these events occur.

Notices to the Office of the Commissioner of Insurance must be written, on the prescribed form, and received at he Office's current address:

P.O. Box 7873 Madison, WI 53707-7873

HMO CAPITAL AND SECURITY SURPLUS

Each HMO is required to meet minimum capital and surplus standard ("compulsory surplus requirements"). These standards are higher if the HMO has fewer than 90% of its liabilities covered by the statutory hold-harmless. Specifically, the compulsory requirements are as follows:

1. From January 1, 1990, through December 31, 1990, at least the greater of $500,000 or 3% of the premiums earned by the HMO in the previous 12 months.
2. From January 1, 1991, through December 31, 1991, at least the greater of $500,000 or 4.5% of the premiums earned by the HMO in the previous 12 months if its covered liabilities are less than 90%, or 3% of the premiums earned by the HMO in the last 12 months if its covered liabilities are 90% or more.
3. Beginning January 1, 1992, at least the greater of $750,000 or 6% of the premiums earned by the HMO in the last 12 months if its covered liabilities are less than 90%, or 3% of the premiums earned by the HMO in the last 12 months if its covered liabilities are 90% or more. In addition to capital and surplus, an HMO must also maintain a security surplus in the amount set by the Commissioner of Insurance.

FINANCIAL INFORMATION

An HMO is required to file financial statements with OCI. You may request financial statements form the HMO. OCI also maintains files of HMO financial statements that can be inspected by the public.