# CHAPTER 200

## INSURANCE DEPARTMENT



**200.17 Fire department dues; lists of towns; payment.** (1) The commissioner shall annually forward to every company transacting fire insurance in this state a list of all cities, villages and towns entitled to fire department dues.

**(2)** Every company effecting fire insurance in any city, village or town entitled to any fire department dues shall, before the first day of March in each year, file with the commissioner a statement, showing the amount of premiums upon said insurance, and pay to him the total amount of such fire department dues. Return premiums, as defined in section 76.30, may be deducted in determining the premium on which the fire department dues are computed.

**(3)** The commissioner shall, before the first day of May in each year, compile the fire department dues paid by all companies, and certify the proper amount for each city, village or town to the department of administration; and such amount shall, upon being audited by the department of administration, be paid by the state treasurer to the respective cities, villages and towns entitled to the same.

**(4)** The commissioner shall include in such compilation and certification of fire department dues the amount of two per centum on the premiums paid the state fire fund for the insurance of any public property, other than state, located within any city, village or town entitled to fire department dues, and the amount of such dues shall be included in the apportionment to such cities, villages and towns; the commissioner shall notify the state treasurer of the amount so certified and the state treasurer shall charge the amount to the state fire fund.

**(4m)** The aggregate payment of fire department dues by the commissioner to cities, villages and towns, maintaining fire departments manned wholly or partly by volunteer firemen, shall be reduced by an amount equal to one-half of the amount appropriated annually for fire training programs under s. 20.292 (1) (c). The amount paid to each such city, village and town shall be reduced on a proportionate basis. Such amounts shall be retained in the general fund for the purposes of the appropriations made under s. 20.292 (1) (c).

**(5)** The commissioner shall transmit to the treasurer of each city, village and town entitled to fire department dues, a statement of the amount of such dues payable to it; and he shall furnish to such treasurer, upon his request, a list of the companies paying such dues and the amount paid by each.

**History:** 1971 c. 154.

**200.26 Nonprofit service plans.** (1) DEFINITION. As used in this section unless the context clearly implies otherwise: "Organization" means any society, organization or corporation, operating a plan of sickness care as permitted by ch. 148, hospital service as permitted by s. 182.032, or a plan of dental care as permitted by s. 447.13, or a prepaid prescription plan as permitted by s. 450.13, or prepaid optometric service plans as permitted by s. 449.15; but when any such plan is operated by any division or agency of any such society, organization or corporation then the term "organization" means only such division or agency.

**(2)** FILING; GENERAL. Any organization subject to this section shall file with the insurance commissioner the following information verified by 2 principal officers of such organization:

(a) A written declaration defining the organization and structure and area of operation of each existing or proposed plan for sickness care as permitted by ch. 148, hospital service as permitted by s. 182.032, or for dental care as permitted by s. 447.13, or a prepaid prescription plan as permitted by s. 450.13, or prepaid optometric service plans as permitted by s. 449.15, and any amendments thereto.

(b) The bylaws, if any, of the organization immediately responsible for such plan and all amendments thereto.

(c) Each form of contract or contractual agreement executed or proposed to be executed by and between the organization and any physicians, dentists, pharmacists, hospital, public party or others embodying the terms under

which sickness care as permitted by ch. 148, hospital service as permitted by s. 182.032, or dental care as permitted by s. 447.13, or prepaid prescription plan as permitted by s. 450.13, or prepaid optometric service plans as permitted by s. 449.15, is to be furnished to subscribers to the plan.

(d) A financial statement of the organization, which shall include the amount of each contribution paid or agreed to be paid to the organization for working capital, the name of each contributor and the terms of each contribution. Any plan in existence on November 6, 1959 shall file such information as to its financial condition and capital as the commissioner requires.

**(3)** FILING OF CONTRACT FORMS. (a) All forms of contracts, riders, endorsements, applications, notices of proposed contracts or other instruments which such organization proposes to issue as part of a contract shall be filed with the commissioner for approval, with a statement of the rate to be charged therefor or the effect such attached paper will have upon the rate, but the rate shall not be a ground for withholding approval unless the rate is unfairly discriminatory. Rates for contracts may reflect a differential attributable to the number of persons covered, actuarial experience or plan of operation under which the contracts are issued without being considered unfairly discriminatory. Contracts filed for approval under this subsection shall not include those referred to in sub. (2) (c).

(b) No such contract shall be issued, nor shall any application, rider or endorsement be used in connection therewith until the expiration of 30 days after it has been so filed unless the commissioner shall sooner give his written approval thereto.

(c) The commissioner may within 30 days after the filing of any such form disapprove such form if it contains a provision which is unjust, unfair, inequitable, misleading, deceptive or encourages misrepresentation of such contract. If the commissioner notifies such organization that the form does not comply with this subsection, it is unlawful thereafter for such organization to issue or use such form. In such notice the commissioner shall specify the reason for his disapproval and state that a hearing will be granted within 20 days after request in writing by the organization.

(d) The commissioner may at any time, after a hearing on not less than 20 days' written notice to such organization, withdraw his approval of any such form on any of such grounds. It is unlawful for such organization to issue such form or use it after the effective date of such withdrawal of approval.

**(4)** SUBJECT TO INSURANCE LAWS FOR CERTAIN PURPOSES. Such organizations and their agents, plans and contracts are subject to s. 201.045 relating to licensing, ch. 207 relating to unfair methods of competition and unfair or deceptive acts or practices, s. 209.04 (11) relating to agents, ch. 601 relating to the administration of the insurance laws, ch. 620 relating to investments, and to ch. 645 relating to delinquency proceedings, to the same extent and in the same manner as if such organizations were domestic insurance corporations. Such organizations are also subject to s. 201.18 (1) relating to premium reserves except that where risks are written for more than one month and the premium or fee is paid on a monthly basis, the reserve shall be computed at 50% of the monthly premium or fee received each month.

**(5)** DIRECT PAYMENT. Any contract may provide that all or any portion of any benefits provided by any such contract may, at the option of the organization, be paid directly to the party rendering such services.

**(6)** REQUIRED COVERAGE OF CERTAIN TREATMENTS. (a) *Definitions.* In this subsection:

1. "Outpatient treatment facility" means a facility whose outpatient services meet the standards established in s. 51.42 (12) and provides at a minimum those services, except inpatient services, enumerated in s. 51.42 (5) (b) to (d) for the prevention and amelioration of mental disabilities, including but not limited to mental and nervous disorders, alcoholism and drug abuse.

2. "Hospital" has the meaning set forth in s. 140.24 (1) (a) and (c) which are licensed under s. 140.26, including an approved public or private treatment facility for the treatment of alcoholics as defined in s. 51.45 (2) (b) and (c).

3. "Physician" means a person licensed to practice medicine and surgery under ch. 448.

(b) *Requirement.* 1. Every contract issued by an organization and providing coverage for hospital treatment shall provide coverage for:

a. Inpatient and outpatient hospital treatment of alcoholism.

b. Inpatient hospital treatment of mental and nervous disorders and drug abuse.

c. Inpatient and outpatient dialysis treatment for kidney disease including home dialysis and kidney transplantation expenses, in an amount not less than $30,000 annually, and including protection for both the recipient and donor of any transplant organ, as provided in s. 49.48 (3) (b). No insurer shall be required to duplicate coverage available under the federal medicare program.

2. Except as provided in this subsection, coverages under this paragraph may not be

subject to exclusions or limitations which are not generally applicable to other conditions covered under the contract.

(c) *Limitation.* Coverages under par. (b) 1. a and b may not provide less than 30 days' confinement in any calendar year.

(d) *Outpatient treatment.* Every contract issued by an organization and providing coverage for outpatient treatment shall provide coverage for outpatient services provided by, under supervision of, or on referral from a physician for mental and nervous disorders, alcoholism and drug abuse including but not limited to partial hospitalization services, prescribed drugs and collateral interviews with patients' families in an amount not less than the first $500 in any 12-month period in a hospital or outpatient treatment facility, or by a physician at any location. The department of health and social services may by rule adopted under ch. 227 adjust this amount at 2-year intervals to reflect changes in the cost of medical care.

(e) *Exclusion.* This subsection does not apply to contracts underwritten for a specific individual or members of his family.

(f) *Kidney diseases.* The department of health and social services may by rule impose reasonable standards for the treatment of kidney diseases required to be covered under this subsection which shall not be inconsistent with or less stringent than applicable federal standards.

**Note: Sub. (6) applies to all nonprofit service plan contracts and all group accident and sickness policies issued or renewed on or after September 1, 1974.**

**(7)** EFFECTIVE DATE. This section shall take effect November 6, 1959 but those portions of sub. (3) relating to approval of contracts shall take effect November 1, 1961, and those portions of sub. (4) relating to agents shall take effect November 1, 1960.

**History:** 1971 c. 260, 325; 1973 c. 198, 308, 333.