CHAPTER 619

RISK SHARING PLANS

SUBCHAPTER I

GENERAL PROVISIONS

619.01 Mandatory risk sharing plans. (1) MANDATORY PLANS. (a) *Establishment of plans.* If the commissioner finds after a hearing that in any part of this state automobile insurance, property insurance, health care liability insurance, municipal liability insurance, worker's compensation insurance, insurance coverage for foster homes or insurance coverage for group homes is not readily available in the voluntary market, and that the public interest requires such availability, the commissioner may by rule either promulgate plans to provide such insurance coverages for any risks in this state which are equitably entitled to but otherwise unable to obtain such coverage, or may call upon the insurance industry to prepare plans for the commissioner's approval.

(b) *Purposes and contents of risk sharing plans.* The plan promulgated or prepared under par. (a) shall:

1. Give consideration to the need for adequate and readily accessible coverage, to alternative methods of improving the market affected, to the preferences of the insurers and agents, to the inherent limitations of the insurance mechanism, to the need for reasonable underwriting standards, and to the requirement of reasonable loss prevention measures;

2. Establish procedures that will create minimum interference with the voluntary market;

3. Spread the burden imposed by the facility equitably and efficiently within the industry; and

4. Establish procedures for applicants and participants to have grievances reviewed by an impartial body.

(c) *Persons required to participate.* 1. Each plan, except a health care liability insurance plan or a foster home protection insurance plan or a group home protection insurance plan, shall require participation by all insurers doing any business in this state of the types covered by the specific plan and all agents licensed to represent such insurers in this state for the specified types of business, except that the commissioner may exclude classes of persons for administrative convenience or because it is not equitable or practicable to require them to participate in the plan.

2. Each health care liability insurance plan shall require participation by all insurers insuring persons in this state against liability resulting from personal injuries. Any deficit in a health care liability insurance plan in any year shall be recouped by rate increases for such plan applicable prospectively. Any surplus over the loss reserves in such a plan in any year shall be distributed by rate decreases for such plan applicable prospectively.

3. No county, town, village or city shall be required to participate in any municipal liability risk-sharing plan promulgated or approved by the commissioner under this section or be assessed for the cost of any such plan in which it is not participating.

4. A foster home protection insurance plan shall require participation by all insurers insuring persons in this state under policies described in subchs. I or III of ch. 632 and all agents licensed to represent such insurers in this state except that the commissioner may exclude classes of persons for administrative convenience or because it is not equitable or practicable to require them to participate in the plan.

5. A group home protection insurance plan shall require participation by all insurers insuring persons in this state under policies described in subchs. I or III of ch. 632 and all agents licensed to represent such insurers in this state except that the commissioner may exclude

classes of persons for administrative convenience or because it is not equitable or practicable to require them to participate in the plan.

(d) *Voluntary participation.* The plan may provide for optional participation by insurers not required to participate under par. (c).

(e) *Classifications and rates.* Each plan shall provide for the method of classifying risks and making and filing rates applicable thereto.

(2) BASIS OF PARTICIPATION. The plan shall specify the basis of participation of insurers and agents and the conditions under which risks must be accepted.

(3) DUTY TO PROVIDE SERVICE. Every participating insurer and agent shall provide to any person seeking coverages of kinds available in the plans the services prescribed in the plans, including full information on the requirements and procedures for obtaining coverage under the plans whenever the business is not placed in the voluntary market.

(4) COMMISSIONS. The plan shall specify what commission rates shall be paid for business placed in the plans.

(5) PROVISION OF MARKETING FACILITIES. If the commissioner finds that the lack of cooperating insurers or agents in an area makes the functioning of the plan difficult, the commissioner may order that the plan set up branch service offices or take other appropriate steps to ensure that service is available.

(6) TRANSITION. The existing assigned risk plan set up under former s. 204.51 (2) [Stats. 1967] and the existing rejected risk plan set up under former s. 205.15 [Stats. 1967] shall continue unless changed in accordance with this chapter.

(7) HEALTH CARE LIABILITY POLICY LIMITS. (a) *Primary coverage plans.* Health care liability insurance plans established under this paragraph shall provide minimum coverage to insureds in the amount of not less than $100,000 for each occurrence and $300,000 for all occurrences in any one policy year for the protection of persons who are legally entitled to recover damages from the insured for errors, omissions or neglect in the performance of the insured's professional services. If an insured has excess limits liability coverage or such coverage is available to the insured, the coverage provided under such plans shall be equal to the minimum level of such excess limits coverage. If the insured does not have excess limits liability coverage and such coverage is not available to the insured, the commissioner may establish minimum levels of coverage higher than the minimum limits specified in this paragraph for such plans.

(b) *Supplemental liability coverage plans.* Health care liability insurance plans of the kind authorized under par. (a) may be established by the commissioner under this paragraph to provide coverage to supplement primary coverage provided by insurers authorized under ch. 611 or 618. Such plans may be in an amount no greater than $100,000 for each occurrence and $300,000 for all occurrences in any one policy year, but the total combined primary and supplemental coverage may not exceed the limits established by s. 655.23 (5).

(8) HEALTH CARE LIABILITY POLICY PROVISIONS. Health care liability insurance plans established under this chapter may include liability coverages normally incidental to health care liability insurance if such coverage is not readily available in the voluntary market.

(9) FOSTER HOME PROTECTION INSURANCE. In this section "foster home protection insurance" means insurance coverage to protect persons who receive a license to operate a foster home as provided in s. 48.62 (1) against the unique risks, determined by the commissioner, to which such persons are exposed. If the persons have insurance which covers any of these risks, the foster home protection insurance may insure against any or all of the other risks, and may provide additional or excess limits coverage for any or all of these risks.

(10) GROUP HOME PROTECTION INSURANCE. In this section "group home protection insurance" means insurance coverage to protect persons who receive a license to operate a group home as provided in s. 48.625 against the unique risks, determined by the commissioner, to which such persons are exposed. If the persons have insurance which covers any of these risks, the group home protection insurance may insure against any or all of the other risks, and may provide additional or excess limits coverage for any or all of these risks.

History: 1975 c. 2, 79; 1975 c. 147 s. 54; 1975 c. 199; 1977 c. 131, 172; 1979 c. 56, 57; 1979 c. 102 s. 236 (6); 1979 c. 177.

619.02 State contribution for federally reinsured losses. (1) ASSESSMENT OF INSURERS. The commissioner is authorized to assess each insurance company authorized to do business in this state an aggregate amount sufficient to provide a fund to reimburse the U.S. secretary of housing and urban development in the manner set forth in sec. 1223 (a) (1) of the national housing act as amended by sec. 1103 of the urban property protection and reinsurance act of 1968, P.L. 90-448, 82 Stat. 476. The assessment shall be on those lines reinsured during the current year in this state by the U.S. secretary of housing and urban development pursuant to

such act. The assessment shall be in the proportion that the premiums earned during the preceding calendar year by each such company in this state bear to the aggregate premiums earned on those lines in this state by all insurers. The fund may be provided in whole or in part from appropriations by the legislature.

(2) RECOUPMENT. Rates used by an insurer shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments made under this section.

619.03 Voluntary risk sharing plans. Insurers doing business within this state are authorized to prepare voluntary plans providing any specified kind, line or class of insurance coverage or subdivision or combination thereof for all or any part of this state in which such insurance is not readily available in the voluntary market and in which the public interest requires the availability of such coverage. Voluntary risk sharing plans shall be submitted to the commissioner and if approved may be put into operation.

History: 1979 c. 102.

619.04 Mandatory health care liability risk sharing plans. (1) The commissioner shall promulgate rules establishing a plan of health care liability coverage for all medical or osteopathic physicians licensed under ch. 448 and nurse anesthetists licensed under ch. 441 who practice in this state; for operating cooperative sickness care plans organized under ss. 185.981 to 185.985 which directly provide services in their own facilities with salaried employes; and for all hospitals as defined by s. 50.33 (1) (a) and (c), but excluding those facilities exempted by s. 50.39 (3), which operate in this state.

(3) The plan shall operate subject to the supervision and approval of a board of governors consisting of representatives of 5 of the insurers participating in the plan, who shall serve at the direction of the commissioner, an attorney to be named by the state bar association, a physician to be named by the Wisconsin medical society, a hospital representative to be named by the Wisconsin hospital association, the commissioner or a designated representative employed by the office of the commissioner and 2 public members who are not attorneys or physicians and who are not professionally affiliated with any hospital or insurance company, appointed by the governor for staggered 3-year terms. The commissioner or the commissioner's representative shall be the chairman of the board of governors. Board members shall be compensated at the rate of $50 per diem plus actual and necessary travel expenses.

(5) The plan shall offer professional health care liability coverage in a standard policy form for all hospitals, medical or osteopathic physicians and nurse anesthetists operating or practicing in this state. The plan shall include, but not be limited to, the following:

(a) Rules for the classification of risks and rates which reflect past and prospective loss and expense experience in different areas of practice.

(b) A rating plan which reasonably recognizes the prior loss experience of insureds in the state.

(c) Provisions as to rates for insureds who are semiretired or part-time professionals.

(d) Optional coverage, available upon request to any insured, for any liability based on a treatment, omission or operation which occurs during the term of the policy and which is brought within the time the applicable statute of limitations continues that liability.

(9) Neither the state nor the board of governors shall be liable for any obligation of the plan or of the patients compensation fund under s. 655.27. The board of governors and members of any committee or subcommittee thereof shall be immune from civil prosecution for good faith actions taken within the scope of their duties under this section and s. 655.27.

(10) The commissioner may promulgate rules to effect coverage under s. 619.01 of the plan established under this section.

History: 1975 c. 37, 79, 199; 1977 c. 131; 1977 c. 203 s. 106.

SUBCHAPTER II

MANDATORY HEALTH INSURANCE RISK SHARING PLAN

619.10 Definitions. In this subchapter:

(1) "Administering carrier" means the insurer designated under s. 619.16.

(2) "Board" means the board of governors established under s. 619.15.

(3) "Eligible person" means a resident of this state who qualifies under s. 619.12 whether or not the person is legally responsible for the payment of medical expenses incurred on the person's behalf.

(4) "Health insurance" means surgical, medical, hospital, major medical and other health service coverage provided on an expense-incurred basis. "Health insurance" does not include ancillary coverages such as income continuation, short-term, accident only, fixed indemnity policies, credit insurance, automobile medical payment coverage, coverage issued as a supplement to liability coverage, loss of time or accident benefits.

(5) "Insurer" means any person or association of persons, including a health maintenance organization, offering or insuring health services on a prepaid basis, including, but not limited to, policies of health insurance issued by a currently licensed insurer, nonprofit hospital or medical service plans under ch. 613, cooperative medical service plans under s. 185.981, or other entity whose primary function is to provide diagnostic, therapeutic or preventive services to a defined population in return for a premium paid on a periodic basis. "Insurer" includes any person providing health services coverage for individuals on a self-insurance basis without the intervention of other entities, as well as any person providing health insurance coverage under a medical reimbursement plan to persons. "Insurer" does not include a plan under ch. 613 which offers only dental care.

(6) "Medical assistance" means health care benefits provided under ss. 49.45 to 49.47.

(7) "Medicare" means coverage under both part A and part B of Title XVIII of the federal social security act, 42 USC 1395 et seq., as amended.

(8) "Plan" means the health care insurance plan established under this subchapter.

(9) "Resident" means a person who has been legally domiciled in this state for a period of at least 30 days. For purposes of this subchapter, legal domicile is established by living in this state and obtaining a Wisconsin motor vehicle operator's license, registering to vote in Wisconsin or filing a Wisconsin income tax return. A child is legally domiciled in this state if the child lives in this state and if at least one of the child's parents or the child's guardian is legally domiciled in this state. A person with a developmental disability or another disability which prevents the person from obtaining a Wisconsin motor vehicle operator's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return, is legally domiciled in this state by living in this state for 30 days.

History: 1979 c. 313.

619.11 Establishment of plan. The commissioner shall promulgate rules establishing a plan of health insurance coverage for an eligible person which satisfies the requirements of this chapter.

History: 1979 c. 313.

619.12 Eligibility determination. (1) Except as provided in sub. (2), the board or administering carrier shall certify as eligible any person upon receipt of any of the following based wholly or partially on medical underwriting considerations within 6 months prior to making application for coverage by the plan:

(a) A notice of rejection or cancellation of coverage from 2 or more insurers.

(b) A notice of reduction or limitation of coverage, including restrictive riders, from an insurer if the effect of the reduction or limitation is to substantially reduce coverage compared to the coverage available to a person considered a standard risk for the type of coverage provided by the plan.

(c) A notice of increase in premium exceeding the premium then in effect for the insured person by 50% or more, unless the increase applies to substantially all of the insurer's health insurance policies then in effect.

(d) A notice of premium for a policy not yet in effect from 2 or more insurers which exceeds the premium applicable to a person considered a standard risk by 50% or more for the types of coverage provided by the plan.

(2) (a) No person who is currently receiving medical assistance benefits is eligible for coverage under the plan.

(b) No person who is covered under the plan and voluntarily terminates the coverage under the plan, is again eligible for coverage unless 12 months have elapsed since the person's latest voluntary termination of coverage under the plan.

(c) No person on whose behalf the plan has paid out $250,000 or more is eligible for coverage under the plan.

(d) No person who is 65 years of age or older is eligible for coverage under the plan.

History: 1979 c. 313.

619.13 Participation of insurers. (1) (a) Every insurer shall participate in the cost of administering the plan.

(b) 1. Except as provided in subd. 2, every participating insurer shall share in the operating and administrative expenses of the plan in proportion to the ratio of the insurer's total cost of premium, subscriber contract charges and health maintenance organization charges on business written in this state on behalf of residents during the preceding calendar year to the aggregate cost of premium, subscriber contract charges, health maintenance organization charges, self-insurance and medical reimbursement charges received by all insurers for health insurance written in this state on behalf of residents during the preceding calendar year, as determined by the commissioner.

2. If the participating insurer is a self-insurer or a provider of health insurance coverage under a medical reimbursement plan, the participating insurer's share in the operating and administrative expenses of the plan shall be proportional to the ratio of the sum of the total benefits paid and the total administrative costs incurred during

the preceding calendar year to residents to the aggregate cost of premium, subscriber contract and health maintenance organization charges, and self-insurance and medicare reimbursement charges received by all insurers on health insurance business written in this state on behalf of residents during the preceding calendar year, as determined by the commissioner.

(c) If assessments and other receipts by the commissioner, board or administering carrier exceed actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board to offset future losses or to reduce plan premiums. In this paragraph, "future losses" includes reserves for incurred but not reported claims.

(d) 1. Each insurer's proportion of participation in the plan shall be determined annually by the commissioner based on annual statements and other reports filed by the insurer with the commissioner.

2. If the commissioner finds that the commissioner's authority to require insurers to report under chs. 600 to 649 is not adequate to permit the commissioner or the board to carry out the commissioner's or the board's responsibilities under this subchapter, the commissioner may promulgate rules requiring insurers to report the information necessary for the commissioner and the board to make the determinations required under this subchapter.

(2) Any deficit incurred under the plan shall be recouped by assessments apportioned under sub. (1) by the board among participating insurers, who may recover these amounts in the normal course of their respective businesses without time limitation.

History: 1979 c. 313.

619.14 Coverage. (1) COVERAGE OFFERED. (a) The plan shall offer in an annually renewable policy the coverage specified in this section for each eligible person. If an eligible person is also eligible for medicare coverage, the plan shall not pay or reimburse any person for expenses paid for by medicare.

(b) If any individual whose coverage under medical assistance is terminated for any reason other than failure to pay any required contribution applies for coverage under the plan within 45 days after the termination and is subsequently found to be eligible under s. 619.12, the effective date of coverage for the eligible person under the plan shall be the date of termination of the previous coverage.

(2) MAJOR MEDICAL EXPENSE COVERAGE. (a) The plan shall provide every eligible person who is not eligible for medicare with major medical expense coverage. Major medical expense coverage offered under the plan shall pay an eligible person's covered expenses, subject to limits on outpatient benefits under sub. (3) (c) and deductible and coinsurance payments authorized under sub. (5), up to a lifetime limit of $250,000 per covered individual. The maximum limit under this paragraph shall not be altered by the board, and no actuarially equivalent benefit may be substituted by the board.

(b) The plan shall provide an alternative policy for those persons eligible for medicare which reduces the benefits payable under par. (a) by the amounts paid under medicare.

(3) COVERED EXPENSES. Covered expenses shall be the usual and customary charges for the services provided by persons licensed under ch. 446. Covered expenses shall also be the usual and customary charges for the following services and articles when prescribed by a physician licensed under ch. 448:

(a) Hospital services.

(b) Basic medical-surgical services, including both in-hospital and out-of-hospital medical and surgical services, diagnostic services, anesthesia services and consultation services and in-hospital and outpatient services as defined by s. 632.89 (1) (d) for alcoholism, drug abuse and mental and nervous disorders provided by a physician or under the supervision, at the direction of or on referral from a physician.

(c) Outpatient treatment for alcoholism, drug abuse and mental and nervous disorders as required under s. 632.89 for group disability policies providing outpatient treatment coverage.

(d) Drugs requiring a physician's prescription.

(e) Services of a licensed skilled nursing facility for eligible persons eligible for medicare, for not more than 120 days during a policy year, if the services are of the type which would qualify as reimbursable services under medicare.

(f) Services of a home health agency, as defined in s. 150.001 (8), if the services are of the type which would qualify as reimbursable services under medicare.

(g) Use of radium or other radioactive materials.

(h) Oxygen.

(i) Anesthetics.

(j) Prostheses other than dental.

(k) Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids.

(L) Diagnostic X-rays and laboratory tests.

(m) Oral surgery for partially or completely unerupted, impacted teeth and oral surgery with respect to tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(n) Services of a physical therapist.

(o) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition.

(p) Services of a licensed skilled nursing facility to the extent required by s. 632.78 (4).

(q) Any other health insurance coverage required under subch. VI of ch. 632.

(r) Processing charges for blood including, but not limited to, the cost of collecting, testing, fractionating and distributing blood.

(4) EXCLUSIONS. Covered expenses shall not include the following:

(a) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect.

(b) Care which is primarily for custodial or domiciliary purposes which do not qualify as eligible services under medicare.

(c) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician. If the institution does not have semiprivate rooms, its most common semiprivate room charge shall be 90% of its lowest private room charge.

(d) That part of any charge for services or articles rendered or prescribed by a physician, dentist or other health care personnel which exceeds the prevailing charge in the locality where the service is provided or any charge not medically necessary.

(e) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles.

(f) Any expense incurred prior to the effective date of coverage under the plan for the person on whose behalf the expense is incurred.

(g) Dental care except as provided in sub. (2) (m).

(h) Eyeglasses and hearing aids.

(i) Routine physical examinations, including routine examinations to determine the need for eyeglasses and hearing aids.

(j) Illness or injury due to acts of war.

(k) Services of blood donors and any fee for failure to replace the first 3 pints of blood provided to an eligible person each policy year.

(L) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

(5) PREMIUMS, DEDUCTIBLES AND COINSURANCE. (a) The plan shall offer a $1,000 annual deductible in combination with appropriate premiums determined under this subchapter for major medical expense coverage required under this section. For coverage offered to those persons eligible for medicare, the plan shall offer a deductible equal to the deductible charged by part A of title XVIII of the federal social security act, as amended. The schedule of premiums and deductibles shall be promulgated by rule by the commissioner. The rating plan shall be designed to be self-sufficient, except that for the first 3 years of its operation, the rating plan shall not provide for rates greater than 130% of the rate which a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under this section.

(b) Except as provided in par. (c), if the covered costs incurred by the eligible person exceed the deductible for major medical expense coverage selected by the person in a policy year, the plan shall pay at least 80% of any additional covered costs incurred by the person during the policy year.

(c) If the aggregate of the covered costs not paid by the plan under par. (b) and the deductible selected by the eligible person covered under a major medical expense policy issued by the plan exceeds $500 for an eligible person receiving medicare, $1,500 for any other eligible person during a policy year or $3,000 for all eligible persons in a family, the plan shall pay 100% of all covered costs incurred by the eligible person during the policy year after the payment ceilings under this paragraph are exceeded.

(6) PREEXISTING CONDITIONS. No person who obtains coverage under the plan may be covered for any preexisting condition during the first 30 days of coverage under the plan if the person was diagnosed or treated for that condition during the 6 months immediately preceding the filing of an application with the plan.

(7) COORDINATION OF BENEFITS. (a) Covered expenses under the plan shall not include any charge for care for injury or disease for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance, for which benefits are payable under a worker's compensation or similar law, or for which benefits are payable under another policy of health care insurance, medicare or any other governmental program, except as otherwise provided by law.

(b) The board has a cause of action against an eligible participant for the recovery of the amount of benefits paid which are not for covered expenses under the plan. Benefits under the plan may be reduced or refused as a setoff against any amount recoverable under this paragraph.

(c) The board is subrogated to the rights of an eligible person to recover special damages for illness or injury to the person caused by the act of a 3rd person to the extent that benefits are provided under the plan.

History: 1979 c. 313.

619.15 Board of governors. (1) The plan shall operate subject to the supervision and approval of a board consisting of representatives of 2 participating insurers which are nonprofit corporations, 2 other participating insurers, and 3 public members, at least 2 of whom are members of the population covered by the plan and who are not professionally affiliated with the practice of medicine, a hospital or an insurance company or association, appointed by the commissioner for staggered 3-year terms. In addition, a representative of the health policy council and the commissioner or a designated representative from the office of the commissioner shall be members of the board. The commissioner or the commissioner's representative shall be the chairperson of the board. Board members, except the commissioner or the commissioner's representative, shall be compensated at the rate of $50 per diem plus actual and necessary expenses.

(2) Annually, the board shall make a report to the members of the plan and to the standing committees on health and insurance in each house of the legislature summarizing the activities of the plan in the preceding calendar year. The annual report shall define the cost burden imposed by the plan on all policyholders in this state.

(3) The board shall:

(a) Establish procedures under which applicants and participants may have grievances reviewed by an impartial body and reported to the board.

(b) Select an administering carrier in accordance with s. 619.16.

(c) Collect assessments from all insurers to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board. Assessment of the insurers shall occur at the end of each calendar year or other fiscal year end established by the board. Assessments are due and payable within 30 days of receipt by the insurer of the assessment notice.

(d) Develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment, and to maintain public awareness of the plan.

(4) The board may:

(a) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance solicitors, agents and brokers, and to the general public in this state.

(b) Provide for reinsurance of risks incurred by the plan, and may enter into reinsurance agreements with insurers to establish a reinsurance plan for risks of coverage described in the plan, or obtain commercial reinsurance to reduce the risk of loss through the pool.

(c) In addition to assessments imposed under sub. (3) (c), levy interim assessments to ensure the financial ability of the plan to cover claims expense and administrative expenses incurred or estimated to be incurred in the operation of the plan prior to the end of the calendar year end or other fiscal year end established by the board. Interim assessments shall be due and payable within 30 days of receipt by an insurer of an interim assessment notice. Interim assessments shall be credited against each insurer's annual assessment.

(5) The commissioner may, by rule, establish additional powers and duties of the board.

(6) If any provision of this subchapter conflicts with s. 625.11 or 625.12, this subchapter prevails.

History: 1979 c. 313.

619.16 Administering carrier. (1) The board shall select an insurer through a competitive bidding process to administer the plan. The board shall evaluate bids submitted under this subsection based on criteria established by the board which shall include:

(a) The insurer's proven ability to handle large group accident and health insurance.

(b) The efficiency of the insurer's claim paying procedures.

(c) An estimate of total charges for administering the plan.

(2) (a) The administering carrier shall serve for a period of 3 years.

(b) At least one year prior to the expiration of each 3-year period of service by an administering carrier, the board shall invite all insurers, including the current administering carrier, to submit bids to serve as the administering carrier for the succeeding 3-year period. Selection of the administering carrier for the succeeding period shall be made at least 6 months prior to the end of the current 3-year period.

(3) (a) The administering carrier shall perform all eligibility and administrative claims payment functions relating to the plan.

(b) The administering carrier shall establish a premium billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis as determined by the board.

(c) The administering carrier shall perform all necessary functions to assure timely payment of benefits to covered persons under the plan, including:

1. Making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made.

2. Evaluating the eligibility of each claim for payment under the plan.

3. Notifying each claimant within 30 days after receiving a properly completed and executed proof of loss whether the claim is accepted, rejected or compromised.

(d) The administering carrier shall submit regular reports to the board regarding the operation of the plan. The frequency, content and form of the report shall be as determined by the board.

(e) The administering carrier shall pay claims expenses from the premium payments received from or on behalf of covered persons under the plan. If the administering carrier's payments for claims expenses exceed the portion of premiums allocated by the board for payment of claims expenses, the board shall provide to the carrier additional funds for payment of claims expenses.

(f) 1. The administering carrier shall be paid as provided in the board's contract with the carrier for its direct and indirect expenses incurred in the performance of its services from the plan premiums.

2. In this paragraph "direct and indirect expenses" shall include that portion of the carrier's audited administrative costs, printing, claims administration, management, building overhead expenses, and other actual operating and administrative expenses approved by the board as allocable to the administration of the plan and included in the bid specifications.

History: 1979 c. 313.

619.17 Contents of plan. The plan shall include, but is not limited to, the following:

(1) A rating plan calculated in accordance with generally accepted actuarial principles. The rating plan shall be designed to be self-sufficient, except during the first 3 years of its operation the rating plan shall not provide for rates greater than 130% of the rate which a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under the plan.

(2) A schedule of premiums, deductibles and coinsurance payments which complies with all requirements of this subchapter.

(3) Procedures for applicants and participants to have grievances reviewed by an impartial body.

History: 1979 c. 313.

619.18 Insurance code applicable. Except as otherwise provided in this subchapter, the plan shall comply and be administered in compliance with chs. 600 to 645.

History: 1979 c. 313.