The bill modifies the definition of an HMO contained in the biennial budget act to include federally qualified HMO's and HMO's organized as cooperatives under ch. 185. By modifying the definition of an HMO, the requirement that an employer offer an open panel plan to employees if the employer offers an HMO will apply to employers which offer federally qualified HMO's or HMO's organized as cooperatives. The language in the definition is also changed to clarify that payments to HMO's by enrollees are not only fixed and periodic but are also a predetermined amount.

The bill allows an HMO operated by an insurer and organized as a domestic stock insurance corporation under ch. 611 or a service insurance corporation under ch. 613 to enter into management contracts. Currently, insurers organized under ch. 611 or 613 are prohibited from entering into these contracts.

The bill eliminates a statutory provision which currently prohibits an insurer from retaining a portion of a health care provider's fee when a fee-for-service payment method is used.

SECTION 1. 611.67 of the statutes is renumbered 611.67 (1) and is amended to read:
611.67 (1) No except as provided in sub. (2), no corporation may be a party to any contract the effect of which is to grant or delegate to any person, to the substantial exclusion of the board, management control of the corporation or of its underwriting, loss adjustment, investment, general servicing or production functions, or other major functions.

SECTION 2. 611.67 (2) of the statutes is created to read:

611.67 (2) Subsection (1) does not apply to management of a health maintenance organization, as defined in s. 628.36 (2m) (a). If a health maintenance organization enters into a management contract, the contract shall be filed with the commissioner. The commissioner may disapprove the contract within 30 days after filing or any reasonable extension to that period, as specified by notice by the commissioner within the original 30-day period. Disapproval by the commissioner shall be based on one of the conditions specified in s. 618.22 (2).

SECTION 3. 628.36 (1) of the statutes is amended to read:

628.36 (1) Payment methods. Any corporation operating a voluntary health care plan may pay health care professionals on a salary, per patient or fee-for-service basis to provide health care to policyholders or beneficiaries of the corporation. No corporation may retain any part of the professional’s fee if a fee-for-service payment basis is used to provide members with health care service.

SECTION 4. 628.36 (2) (a) and (2m) (a) and (b) of the statutes, as created by 1983 Wisconsin Act 27, are amended to read:

628.36 (2) (a) (intro.) In this subsection:

(2m) (a) In this subsection, “health maintenance organization” means an organization, other than a federally-qualified health maintenance organization, organized under the laws of this state, except including ch. 185, and which makes available to enrolled participants, in consideration of predetermined periodic fixed payments, comprehensive health care services provided by providers who are selected by the organization and who are employees or partners of the organization or who have entered into a referral or contractual arrangement with the organization.

(b) Subject to chs. 600 to 646, except sub. (2) (b), or subject to ch. 185, any person may establish or operate a health maintenance organization.

SECTION 5. Cross-reference changes. In the sections of the statutes listed in Column A, the cross-references shown in Column B are changed to the cross-references shown in Column C:

<table>
<thead>
<tr>
<th>Statute Sections</th>
<th>Old Cross-References</th>
<th>New Cross-References</th>
</tr>
</thead>
<tbody>
<tr>
<td>611.51 (6)</td>
<td>181.25 (2) and 611.56</td>
<td>181.25 (2), 611.56 and 611.57</td>
</tr>
</tbody>
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