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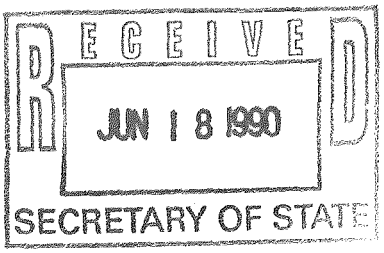

STATE OF WISCONSIN)
)
OFFICE OF THE COMMISSIONER OF INSURANCE)

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Robert D. Haase, Commissioner of Insurance and custodian of the official records of said Office, do hereby certify that the annexed order repealing, renumbering, amending, recreating, and creating a rule relating to regulation of insurers writing health maintenance organization business was issued by this Office on June 18, 1990.

I further certify that said copy has been compared by me with the original on file in this Office and that the same is a true copy thereof, and of the whole of such original.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name in the City of Madison, State of Wisconsin, this 18th day of June 1990.

Robert D. Haase

Robert D. Haase
Commissioner of Insurance

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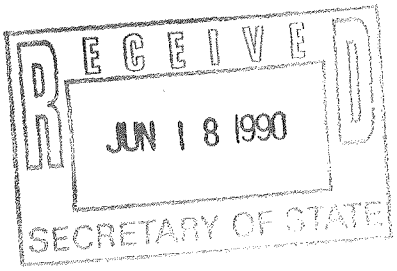

ORDER OF THE COMMISSIONER OF INSURANCE

To repeal ss. Ins 3.50 (3) (a) and (4) (e); to renumber ss. Ins 3.50 (4) (f) and 3.51; to renumber and amend ss. Ins 3.50 (4) (g); to amend ss. Ins 3.50 (4) (d) (intro.), (e) (intro)., as renumbered, (5) (intro.), (a), (b), (d) 2, and (h), (6), (7), and 7.02 (1); to repeal and recreate ss. Ins 3.50 (2), (4) (a) to (c); to create ss. Ins 3.50 (3) (intro.) and (e), (8) (c), (d) and (e), (8g), (8m), (8s), (8u), (8x), (8z), and 3.51, relating to regulation of insurers writing health maintenance organization business, statutory hold-harmless provisions, and individual practice associations.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3), 601.42 (1r) and (2), 609.03 (3) (b), 609.96, 609.97, and 623.03, Stats.

Statutes interpreted: ss. 601.42 (1r), (2) and (3), 601.43 (1) (c), 609.03 (3) (a) 3, 609.92, 609.925, 609.93, 609.935, 609.94, 609.96, 609.97, 618.11, 618.12, 623.03, 623.11, and 645.41 (8), Stats.

This rule makes several changes in the financial standards applicable to insurers who engage primarily in health maintenance organization business

("HMO insurers"); revises and adds reporting requirements for HMO insurers and Individual Practice Associations ("IPAs"); and prescribes various forms which must be used as part of the statutory provisions which govern when a health care provider may bill an HMO enrollee for services covered by the HMO.

Financial Standards

This rule:

1. Makes it clear that an HMO insurer may be required to maintain more than the minimum compulsory surplus if appropriate given the risks and operations of the HMO insurer, including, but not limited to, inadequate transfer of risk to health care providers.

2. Requires an HMO insurer to value receivables, notes or obligations of or from an affiliate at zero unless the Commissioner approves a different value. A different value may be approved only if the receivable, note, or other obligation is fully secured by cash or cash equivalents.

3. Requires HMO insurers to value receivables, notes, or obligations of or from IPAs at zero after December 31, 1990, except to the extent they are fully secured by cash or cash equivalents in a segregated account.

4. Prohibits an HMO insurer from engaging in issuing indemnity coverage if the coverage is marketed by the insurer or if the premium for policies containing this type of coverage will represent or is projected to represent more than 5% of the premium the insurer receives. The rule allows the commissioner to permit an HMO insurer to market innovative products such as policies with point of service coverage in accordance with a business plan and with increased compulsory surplus requirements. Premium for policies with this type of coverage may not exceed 10% of the total premium.

5. Requires out-of-state health maintenance organizations and limited service health organizations to be organized and regulated as insurance companies to qualify for licensing to do business in this state.

Reports

The rule requires:

1. HMO insurers to file quarterly and annual reports regarding the extent that their expenses are covered by the statutory provision which prohibits a health care provider from billing enrollees. The annual report must include a special procedures opinion in a prescribed form and the audited financial statements must also include a report and opinion.

2. Requires IPAs to file annually, within 180 days after the end of their fiscal year, audited financial statements prepared according to generally accepted accounting principles.

3. HMO insurers to include provisions in their IPA contracts which will enable the IPA to have a timely audit conducted and ensure the separate corporate status of the IPA.

Forms

The rule prescribes forms which must be used by providers who "opt-out" of, "opt-in," or terminate "opt-out" or "opt-in" under the statutory hold-harmless provisions. It requires strict use of the form if an "opt-out" or termination of an "opt-in" is to be effective. The rule also prescribes the form of the summary HMO insurers must provide to health care providers concerning the statutory hold-harmless provision and HMO insurer's capital requirements.

The rule eliminates the requirement that insurers which write both health maintenance organization and indemnity health insurance business file business plans and provider contracts.

SECTION 1. Section Ins 3.50 (2) is repealed and recreated to read:

Ins 3.50 (2) SCOPE. This section applies to all insurers writing health maintenance organization business in this state.

SECTION 2. Section Ins. 3.50 (3) (intro) is created to read:

Ins 3.50 (3) (intro.) DEFINITIONS. In this section:

SECTION 3. Section Ins 3.50 (3) (a) is repealed.

SECTION 4. Section Ins. 3.50 (3) (e) is created to read:

Ins 3.50 (e) "Health maintenance organization insurer" has the meaning provided under s. 600.03 (23c), Stats. "Health maintenance organization insurer" does not include a limited service health organization.

SECTION 5. Ins 3.50 (4) (a) to (c) are repealed and recreated to read:

Ins 3.50 (4) (a) Capital. Unless otherwise ordered by the commissioner the minimum capital or permanent surplus of:

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

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

3. Any other insurer writing health maintenance organization business, is the amount of capital or required surplus required under the statutes governing the organization of the insurer.

(b) Compulsory Surplus. An insurer, including an insurer organized under ch. 613, Stats., writing health maintenance organization business, except for a health maintenance organization insurer, is subject to s. Ins 14.02. A health maintenance organization insurer shall maintain

compulsory surplus as follows, or a greater amount required by order of the commissioner:

1. Prior to January 1, 1991, at least the greater of $500,000 or an amount equal to the sum of:

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

b. 3% of all other premium earned in the previous 12 months.

2. In calendar year 1991, at least the greater of $500,000 or an amount equal to the sum of:

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

b. 3% of other premiums 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%, 4.5% of other premium earned in the previous 12 months.

3. Beginning on January 1, 1992, at least the greater of $750,000 or an amount equal to the sum of:

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

b. 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.

(c) 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 sub. (5) (d).

SECTION 6. Ins 3.50 (4) (d) (intro.) is amended to read:

Ins 3.50 (4) (d) Security surplus. (intro.) ~~The~~ An insurer, including an insurer organized under ch. 613, Stats., writing health maintenance organization insurance business, except for a health maintenance organization insurer, is subject to s. Ins 14.02. A health maintenance organization insurer should maintain a security surplus to provide an ample margin of safety and clearly assure a sound operation. The security surplus of ~~an~~ a health maintenance organization insurer shall be at least the greater of:

SECTION 7. Ins 3.50 (4) (e) is repealed.

SECTION 8. Ins 3.50 (4) (f) is renumbered Ins 3.50 (4) (e) and Ins 3.50 (4) (e) (intro.), as renumbered, is amended to read:

Ins 3.50 (4) (e) (intro.) Insolvency protection for policyholders. Each health maintenance organization insurer is required to either maintain compulsory surplus as required for other insurers under s. Ins 14.02 or to demonstrate that in the event of insolvency:

SECTION 9. Ins 3.50 (4) (g) is renumbered Ins 3.50 (4) (f) and amended to read:

Ins 3.50 (4) (f) Setting greater amounts. The commissioner may set greater amounts under (a), to ~~(c),-(d),-or-(e)~~ on finding that the financial stability of the organization requires it.

SECTION 10. Ins 3.50 (5) (intro.), (a), (b), (d) 2, (e), and (h) are amended to read:

Ins 3.50 (5) BUSINESS PLAN. All applications for certificates of incorporation and certificates of authority of a health maintenance organization insurer shall include a proposed business plan. ~~Health maintenance organizations subject to this section which are not separately licensed shall submit a proposed business plan prior to doing business as a health maintenance organization unless the commissioner waives this requirement.~~--In addition to the items listed in ss. 611.13 (2) and 613.13 (1), Stats., the following information shall be contained in the business plan:

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

(b) Feasibility studies and marketing surveys. A summary of feasibility studies or marketing surveys which support the financial and enrollment projections for the ~~plan~~ health maintenance organization insurer. 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.

(d) 2. 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 earnings of losses; and

(e) 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.

(h) 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 ~~plan~~ health maintenance organization insurer. These include hold harmless agreements by providers, insolvency insurance, reinsurance or other guarantees.

SECTION 11. Ins 3.50 (6), (7) and (8) are amended to read:

Ins 3.50 (6) CHANGES IN THE BUSINESS PLAN. ~~(a) All substantial changes, alterations or amendments to the business plan shall be filed with the commissioner at least 30 days prior to their effective date and shall be subject to disapproved by the commissioner.~~ A health maintenance organization insurer 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. ~~These~~ 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 sub. (5) (d) shall be filed under this section.

(7) COPIES OF PROVIDER AGREEMENTS. All health maintenance ~~organizations subject to this section~~ organization insurers 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, except that, for contracts with physicians, a list of physicians executing a standard contract and a copy of the form of the contract may be filed instead of copies of the executed contracts. Executed copies of all provider agreements, including those with physicians, shall be maintained in the ~~health maintenance organization's~~ insurer's administrative office and shall be made available to the commissioner on request.

(8) OTHER REPORTING REQUIREMENTS. (a) All ~~separately licensed~~ insurers authorized to write health maintenance ~~organizations~~ organization business shall file with the commissioner by March 1 of each year an annual statement for the preceding year. ~~The statement~~ A health maintenance organization insurer shall ~~be on~~ use the current Health Maintenance Organization annual statement blank prepared by the national association of insurance commissioners. All ~~organizations which are not separately licensed~~ other insurers shall file an annual report in a form prescribed by the commissioner. A health maintenance organization insurer shall include with its annual statment a statement of covered expenses, and a special procedures opinion from a certified public accountant, in the form prescribed by the commissioner as Appendix B.

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

SECTION 12. Ins 3.50 (8) (c), (d) and (e) are created to read:

Ins 3.50 (8) (c) A health maintenance organization insurer shall include with its annual audit financial reports filed under s. 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 C.

(d) 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 quarters of the year unless the commissioner notifies the insurer that another reporting schedule is appropriate.

(e) 1. If a health maintenance organization insurer fails to file a statement or opinion required under pars. (a) to (c) 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.

2. 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 pars. (a) to (d) for the most recent period.

3. The health maintenance organization insurer has the burden of refuting a presumption under subd. 1 or 2.

SECTION 13. Ins 3.50 (8g), (8m), (8s), (8u), (8x), and (8z) are created to read:

Ins 3.50 (8g) TERMINATION OF HOLD HARMLESS. (1) Notice of election to be exempt from s. 609.91 (1) (b), Stats., or notice of termination of election to be subject to s. 609.91 (1) (c), Stats., is effective only if filed on the form prescribed by the commissioner and if the form is properly completed.

(2) A health care provider shall use the form prescribed by the commissioner for filing notice of termination of election to be exempt under s. 609.91 (1) (b), Stats., or notice of termination of election to be subject to s. 609.91 (1) (c), Stats. A filing which is not on the prescribed form is not effective. If a provider fails to use or to properly complete the form prescribed for notice of termination of election to be exempt from s. 609.91 (1) (b), Stats., or notice of election to be subject to s. 609.91 (1) (c), Stats., the filing is nevertheless effective.

(8m) RECEIVABLES FROM AFFILIATES. A receivable, note or other obligation of an affiliate to a health maintenance 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.

(8s) 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.

(8u) INCIDENTAL OR IMMATERIAL INDEMNITY BUSINESS IN HEALTH MAINTENANCE ORGANIZATIONS. (a) Except as provided by par. (b), insurance business is not incidental or immaterial under s. ~~609.93~~ 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 either:

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1. Markets the policy containing the coverage; or

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

(b) Insurance business is incidental or immaterial under s. ~~609.93~~ 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. ~~609.93~~ 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 controled, and other information prescribed by the office. The total premium for policies containing coverages subject to this paragraph and policies issued under par. (a) may not exceed 10% of premium earned or projected to be earned in any 12-month period.

(c) If the commissioner approves insurance business as incidental or immaterial the commissioner may also, by order under sub. (4) (b), require the insurer to maintain more than the minimum compulsory surplus.

(d) For the purpose of this section any coverage which covers services by a provider other than a selected provider is not typically

included in a health maintenance organization or limited service health organization policy, except coverage of emergency out-of-area services.

(8x) SUMMARY. A health maintenance organization insurer shall use the form prescribed in Appendix A to comply with s. 609.94, Stats.

(8z) NONDOMESTIC HMO. No certificate of authority may be issued under ch. 618, Stats., on or after the effective date of this rule 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.

SECTION 14. Ins 3.51 is renumbered Ins 3.52.

SECTION 15. Ins 3.51 is created to read:

Ins 3.51 REPORTS BY INDIVIDUAL PRACTICE ASSOCIATIONS. (1) DEFINITIONS. For the purpose of this section only:

(a) "Accountant" means an independent certified public accountant who is duly registered to practice and in good standing under the laws of this state or a state with similar licensing requirements.

(b) "Individual practice association" means an individual practice association as defined under s. 600.03 (23g), Stats., which contracts with a health maintenance organization insurer or a limited service health organization to provide health care services which are principally physician services.

(c) "Work papers" are the records kept by the accountant of the procedures followed, the tests performed, the information obtained, and conclusions reached pertinent to the examination of the financial statements of the independent practice association. Work papers include, but are not limited to, work programs, analysis, memorandum, letters of confirmation and representation, management letters, abstracts of company documents and schedules or commentaries prepared or obtained by the accountant in the course of the examination of the financial statements of the independent practice association and which support the accountant's opinion.

(2) FILING OF ANNUAL AUDITED FINANCIAL REPORTS. Unless otherwise ordered by the commissioner, an individual practice association shall file an annual audited financial report with the commissioner within 180 days after the end of each individual practice association's fiscal year. This section applies to individual practice associations for fiscal years terminating on or after March 31, 1991. The annual audited financial report shall report the assets, liabilities and net worth; the results of operations; and the changes in net worth for the fiscal year then ended on the accrual basis in conformity with generally accepted accounting practices. The annual audited financial report shall not be presented on the cash basis or the income tax basis or any other basis that does not fully account for all the independent practice association's liabilities incurred as of the end of the fiscal year. The annual audited financial report shall include all of the following:

(a) Report of independent certified public accountant.

(b) Balance sheet.

(c) Statement of gain or loss from operations.

(d) Statement of changes in financial position.

(e) Statement of changes in net worth.

(f) Notes to the financial statements. These notes shall include those needed for fair presentation and disclosure.

(g) Supplemental data and information which the commissioner may from time to time require to be disclosed.

(3) SCOPE OF AUDIT AND REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT. (a) Financial statements filed under sub. (2) shall be audited by an independent certified public accountant. The audit shall be conducted in accordance with generally accepted auditing standards. The commissioner may from time to time require that additional auditing procedures be observed by the accountant in the audit of the financial statements of the independent practice association under this rule.

(4) AVAILABILITY AND MAINTENANCE OF CPA WORK PAPERS. (a) An independent practice association required to file an audited financial report under this rule, shall, if requested by the office, require the accountant to make available to the office all the work papers prepared in the conduct of the audit. The independent practice association shall require that the accountant retain the audit work papers for a period of not less than 5 years after the period reported.

(b) The office may photocopy pertinent audit work papers. These copies are part of the office's work papers. Audit work papers are confidential unless the commissioner determines disclosure is necessary to carry out the functions of the office.

(5) CONTRACTS. A health maintenance organization insurer contracting with an independent practice association shall include provisions in the contract which are necessary to enable the individual practice association to comply with this section, including, but not limited to:

(a) Provisions providing for timely access to records;

(b) Provisions providing for maintenance of necessary records and systems and segregation of records, accounts and assets; and

(c) Other provisions necessary to ensure that the individual practice associate operates as an entity distinct from the insurer.

SECTION 16. Ins 7.02 (1) is amended by inserting reference to the following forms:

22-500	Schedule of Covered Expenses
22-510	Election of Exemption (Opt-out)
22-520	Election to be Subject to Restrictions (Opt-in)
22-530	Termination of Exemption (Opt-out)
22-540	Termination of Election (Opt-in)

EFFECTIVE DATE. Pursuant to s. 227.22 (2), Stats., this rule amendment shall be effective on the first day of the month commencing after the date of publication.

Dated at Madison, Wisconsin, this 18th day of June, 1990.

Robert D. Haase
Commissioner of Insurance

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Appendix A

N O T I C E

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 from 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 affect the liability of an enrollee for any deductibles or copayments, or for premiums owed under the policy, or certificate issued by the HMO.

OCI 22-630 (R 2/90)

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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 Social 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 which 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 or 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 HMO 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 condition 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 the 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 31, 1990, at least sixty (60) days 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 from 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 the Office's current address:

(insert OCI's current address)

HMO CAPITAL AND SECURITY SURPLUS

Each HMO is required to meet minimum capital and surplus standards ("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 surplus 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 from the HMO. OCI also maintains files of HMO financial statements which can be inspected by the public.

OCI 22-630 (R 2/90)

Appendix B

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 s. Ins 3.50, 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

OCI 22-62 (R 2/90)

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04/11/90

Appendix C

AUDITORS' REPORT ON 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 XXXXXXX 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.

CPA Signature

OCI 22-62 (R 2/90)

SCHEDULE OF COVERED EXPENSES
Health Maintenance Organizations

Ref: s. 601.42(1g)(d) and 609.01, Wis. Stat.

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707

INSTRUCTIONS: List all covered expenses by provider. Covered expenses are those expenditures and outstanding liabilities of the HMO for health care cost for which an enrollee is not liable under s. 609.01, Wis. Stat. Section I of this form is used to report expenses to providers subject to Mandatory Holdharmless. These are expenses subject to s. 609.91 (1) (a), (am), or (lm), Wis. Stat. Section II of this form (reverse) is used to report covered expenses to a provider which are not subject to the Mandatory Holdharmless but for which the provider may "opt-out" of the holdharmless. These generally are expenses to IPAs or hospitals or to selected providers for physician services. Such providers should not be included, however, if the provider has filed an "opt-out" form with the Commissioner. Section II should also include expenses to any other provider which has filed an "opt-in" form with the Commissioner. Attach additional copies of this form if more space is needed. Section III, Line A, should be the total of all covered expenses listed on this form. Expenses are to be reported on a cumulative basis; i.e., second quarter filings should include both first and second quarter expenses. Covered expenses for incurred but not reported expenses should be estimated based on historical data and the best information available to the HMO. Total medical expenses should be the sum of the medical and hospital expenses on "Report #2" of the current financial statement, less reinsurance expenses and incentive pool adjustments.

HMO Name	As of Date

SECTION I - MANDATORY HOLDHARMLESS PROVIDERS

A. Hospitals

Name	Amount	Name	Amount
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____

B. IPAs

Name	Amount	Name	Amount
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____

C. Selected Providers

Name	Amount	Name	Amount
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____

SECTION II - OTHER PROVIDERS

A. Hospitals

Name	Amount	Name	Amount
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____

B. IPAs

Name	Amount	Name	Amount
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____

C. Selected Providers

Name	Amount	Name	Amount
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____

D. Other "Opted-In" Providers

Name	Amount	Name	Amount
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____

SECTION III

A.	Total Covered Expenditures (Total of Section I and II)	$_____
B.	Estimated Covered IBNR	$_____
C.	Total Covered Expenses (Sum of Lines A and B)	$_____
D.	Total Medical and Hospital Expenses (Annual or Quarterly Statement Page 4, Line 20 minus Lines 17 and 19)	$_____
E.	Percentage (C/D) x 100	_____%

ELECTION OF EXEMPTION (OPT-OUT)

Ref: s. 609.91(1)(b), Wis. Stat.

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707

INSTRUCTIONS: Except as provided in s. 609.93, Wis. Stat., a health care provider may elect to be exempt from the s. 609.91(1)(b), Wis. Stat., provisions for statutory immunity of HMO participants for health care costs liability. The health care provider must submit to the Office of the Commissioner of Insurance a separate Election of Exemption form for each individual HMO insurer to which the exemption is to apply. The Election may be terminated by either providing a termination date on this form or by filing a Termination of Election form with the Commissioner. A provider under this contract with the HMO must give this notice to the Commissioner within 30 days of entering the contract. If you are filing Election of Exemption for services which are not under contract, Election must be received by the Office 60 days in advance if it is to be effective in 1990 or 90 days in advance if it is to be effective in 1991 or subsequent years.

NOTE: A member of an IPA may not file this Election. Only the IPA may file this Election for health care provided by members of the IPA.

Insert requested information and send original to the Office of the Commissioner of Insurance, a photocopy to the subject HMO, and retain a photocopy for your records.

Legal Name of Provider			
Mailing Address	City	State	Zip Code
Contact Person	Phone Number		
Does This Election Apply to a Contract With the HMO	Yes_____	No_____	
Date Contract Was Entered Into (Attach a Copy of the Contract)			
HMO for Which Opt-Out is Applicable			

The undersigned health care provider hereby elects under s. 609.92, Wis. Stat., to opt-out; that is to be exempt from the s. 609.91(1)(b), Wis. Stat., provisions of statutory immunity for HMO enrollees for health care cost liability for enrolled participants of the above-specified health maintenance organization insurer. The undersigned has authority to make this election. This election may be terminated only by giving written notice to the specified HMO and the Commissioner of Insurance, if no stated date of termination is provided here:

Termination Date (Optional)	
Name (Print or Type)	Title
Signature	Date

ELECTION TO BE SUBJECT TO RESTRICTIONS (OPT-IN)

Ref: s. 609.925, Wis. Stat.

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707

INSTRUCTIONS: A provider who is not under contract or not a selected provider may elect to be subject (opt-in) to the provisions of s. 609.91(c), Wis. Stat., for statutory immunity of HMO participants for health care costs liability. The health care provider must submit to the Office of the Commissioner of Insurance a separate Election form for each individual HMO insurer to which the Election is to apply. The Election may be terminated by either providing a termination date on this form or by filing a Termination of Election (Opt-in) form with the Commissioner.

Insert requested information and send original to the Office of the Commissioner of Insurance, a photocopy to the subject HMO, and retain a photocopy for your records.

Legal Name of Provider			
Mailing Address	City	State	Zip Code
Contact Person	Phone Number		
HMO for Which Opt-In is Applicable			

The undersigned health care provider hereby elects under s. 609.925, Wis. Stat., to "opt-in"; that is to be subject to s. 609.91(1)(c), Wis. Stat., provisions of statutory immunity for HMO enrollees for health care cost liability for enrolled participants of the above-specified health maintenance organization insurer. The undersigned has authority to make this election. This election may be terminated only by giving written notice to the Commissioner of Insurance, if no stated date of termination is provided here:

Termination Date (Optional)	
Name (Print or Type)	Title
Signature	Date

TERMINATION OF EXEMPTION
(TERMINATION OF OPT-OUT)

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707

Ref: s. 609.92, Wis. Stat.

INSTRUCTIONS: Except as provided in s. 609.93, Wis. Stat., a health care provider may elect to be exempt from the s. 609.91(1)(b), Wis. Stat., provisions for statutory immunity of HMO participants for health care costs liability. This form is for terminating a prior Election to opt-out from the statutory immunity provisions of s. 609.91, Wis. Stat.

Complete the information requested and file the original with the Office of the Commissioner of Insurance and a photocopy with the HMO. Retain a photocopy for your records.

The termination date may not be earlier than the date this notice is received by the Office.

Legal Name of Provider			
Mailing Address	City	State	Zip Code
Contact Person	Phone Number		
Effective Date of Termination			
HMO for Which Opt-Out is Applicable			

The undersigned health care provider hereby elects under s. 609.92 (4), Wis. Stat., to terminate its prior election to "opt-out" (that is to be exempt from the s. 609.91(1)(b), Wis. Stat., provisions of statutory immunity for HMO enrollees for health care cost liability) for enrolled participants of the above-specified health maintenance organization insurer. The undersigned has authority to make this election.

Name (Print or Type)	Title
Signature	Date