

1975 Senate Bill 17

Date published: May 4, 1976

CHAPTER 223, Laws of 1975

AN ACT to repeal 182.032, 200.26, 204.321 (2) (d), 204.323, 207.04 (1) (k), 209.04 (11) and 600.03 (33); to amend 71.01 (2), (3) (a) and (4) (a) (intro.) and (c) (intro.), 108.02 (4) (a) and (d), 201.045 (1), 207.04 (1) (m), 209.047, 600.03 (6), 601.31 (25) and (26), 610.47 and 645.02 (5); to repeal and recreate 148.03, 447.13, 449.15 and 450.13; and to create 600.03 (41m), 610.46, chapter 613, chapter 628 (title), 628.22, 628.35, 628.36, 628.37, chapter 632 (title), 632.86, 632.87, 632.89 and 632.90 of the statutes, relating to a general revision of the insurance law relating to service insurance corporations and the tax exemption for hospital service insurance corporations and granting rule-making authority.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 71.01 (2), (3) (a) and (4) (a) (intro.) and (c) (intro.) of the statutes are amended to read:

71.01 (2) FRANCHISE TAX ON CORPORATIONS. For the privilege of exercising its franchise or doing business in this state in a corporate capacity every domestic or foreign corporation, except corporations specified in sub. (3), shall annually pay a franchise tax according to or measured by its entire net income of the preceding income year at the rates set forth in s. 71.09 (2am). Every corporation organized under the laws of this state shall be deemed to be residing within this state for the purposes of this franchise tax. All provisions of chs. 71 and 73 relating to net income taxation of corporations shall apply to franchise taxes imposed under this subsection, unless the context requires otherwise. The tax imposed by this subsection on national banking associations shall be in lieu of all taxes imposed by this state on national banking associations to the extent it is not permissible to tax such associations under federal law. The tax imposed by this subsection on insurance companies subject to taxation under this chapter, except societies, organizations or corporations ~~(including any division or agency of any such society, organization or corporation) operating plans of sickness care under ch. 148, hospital service under s. 182.032, dental care under s. 447.13, prepaid prescription plans under s. 450.13, or prepaid optometric service plans under s. 449.15 under ch. 613 operating by virtue of s. 148.03, 447.13, 449.15, 450.13 or 613.80,~~ shall be based on net income computed under sub. (4), and no other provision of this chapter relating to computation of taxable income for other corporations shall apply to such insurance companies. All other provisions of this chapter shall apply to insurance companies subject to taxation under this chapter unless the context clearly requires otherwise. The tax imposed upon societies, organizations or corporations ~~(including any division or agency of any such society, organization or corporation) operating plans of sickness care under ch. 148, hospital service under s. 182.032, dental care under s. 447.13, prepaid prescription plans under s. 450.13, or prepaid optometric service plans under s. 449.15 under ch. 613 operating by virtue of s. 148.03, 447.13, 449.15, 450.13 or 613.80,~~ shall be upon such net income

as is determined by application to such companies of those provisions of the internal revenue code applicable to mutual insurance companies, other than life insurance companies or mutual marine insurance companies, having total receipts over \$500,000 subject to any applicable addition or subtraction as provided in sub. (4) (a).

(3) (a) Income of mutual insurance companies exempt from federal income taxation pursuant to section 501 (c) (15) of the internal revenue code, town mutual insurance companies organized under or subject to ch. 612, foreign insurance companies, and domestic life insurance companies engaged exclusively in life insurance business, domestic insurance companies transacting business as defined in s. 201.04 (19), railroad corporations and sleeping car companies, of car line companies from operation of car line equipment as defined in s. 76.39, and corporations organized under ch. 185 which are bona fide cooperatives operated without pecuniary profit to any shareholder or member, or operated on a cooperative plan pursuant to which they determine and distribute their proceeds in substantial compliance with s. 185.45, and of all religious, scientific, educational, benevolent or other corporations or associations of individuals not organized or conducted for pecuniary profit. This paragraph does not apply to the income of mutual savings banks, mutual loan corporations, savings and loan associations or credit unions except credit unions the membership of which is limited to groups having a common bond of occupation, or association, or to groups within a well-defined neighborhood, community or rural district. Beginning with calendar year 1972 and thereafter, this paragraph shall not apply to the income of societies, organizations or corporations ~~(including any division or agency of any such society, organization or corporation) operating plans of sickness care under ch. 148, hospital service under s. 182.032, dental care under s. 447.13, prepaid prescription plans under s. 450.13, or prepaid optometric service plans under s. 449.15~~ under ch. 613 operating by virtue of ss. 148.03, 447.13, 449.15, 450.13 or 613.80. Tax on the income of such societies, organizations or corporations shall first be payable on or before March 15, 1973, and thereafter under s. 71.10 (1).

(4) (a) (intro.) Insurance companies subject to taxation under this chapter, except societies, organizations or corporations ~~(including any division or agency of any such society, organization or corporation) operating plans of sickness care under ch. 148, hospital service under s. 182.032, dental care under s. 447.13, prepaid prescription plans under s. 450.13, or prepaid optometric service plans under s. 449.15~~ under ch. 613 operating by virtue of s. 148.03, 447.13, 449.15, 450.13 or 613.80, beginning with calendar year 1972 and thereafter, shall be taxed on the basis of net income. Such tax shall first be payable on or before March 15, 1973, and thereafter under s. 71.10 (1). "Net income" of an insurance company subject to taxation under this chapter means federal taxable income as determined in accordance with the provisions of the internal revenue code applicable to such company with respect to determination of federal income tax payable by such company, adjusted as follows:

(c) With respect to domestic insurance companies not engaged in sale of life insurance ~~and or not covered operating under ch. 613 by virtue of s. 182.032 148.03, 447.13, 450.13 or, 449.15 or 613.80~~ or 613.80 but which, in the taxable year, have collected premiums written on subjects of insurance resident, located or to be performed outside this state, there shall be subtracted from the net income figure derived by application of par. (a) to arrive at Wisconsin income constituting the measure of the franchise tax an amount calculated by multiplying such adjusted federal taxable income by the arithmetic average of the following 2 percentages:

SECTION 2. 108.02 (4) (a) and (d) of the statutes are amended to read:

108.02 (4) (a) "Employer", except where the term by its context may apply to any unit employing one or more individuals, means any person, partnership, association, corporation, whether domestic or foreign (or legal representative, trustee

in bankruptcy or receiver or trustee of a person, partnership, association or corporation, or legal representative of a deceased person), including every school district, every other government unit other than a county, city, village or town whose population, according to the latest available federal decennial census figures, does not exceed 5,000 and any fraternal benefit society as defined in s. 208.01, who is subject to this chapter under the statutes of 1971, or who has had employment in this state and becomes subject to this chapter under this subsection and, notwithstanding any other provisions of this section, any service insurance corporation organized or operating under ch. 613. This paragraph is subject to the effective dates provided under pars. (ag) and (ar).

(d) Any other employer who is subject to the federal unemployment tax act for any calendar year, or who, as a condition for approval of this chapter for full tax credit against the tax imposed by the federal unemployment tax act, is required, pursuant to such act, to be an employer under this chapter, shall be an employer subject hereto as of the beginning of such calendar year. ~~This paragraph also applies to any employer described in s. 182.032.~~

NOTE: This SECTION subjects service insurance corporations to unemployment compensation law. It continues the change made by chapter 53, laws of 1971.

SECTION 3. 148.03 of the statutes is repealed and recreated to read:

148.03 Service insurance corporations for health care. The state medical society or, in a manner approved by the state society, a county society, may establish in one or more counties of this state a service insurance corporation for health care under ch. 613.

NOTE ON ss. 148.03, 447.13, 449.15 and 450.13: Chapter 613 provides in general terms for the creation, governance and regulation of service insurance corporations for any kind of health care, as well as for other types of services. All that is needed in each authorizing chapter for professional societies is a brief section giving the appropriate professional society the power to organize a ch. 613 corporation. Section 148.03 creates that section for health care.

One basic restriction results from the repeal of the old enabling sections: none of the professional societies will be able to organize a service insurance plan within its own corporate structure. It is a mistake to permit such a mixing of professional and insurance activities within the same corporation. The society can, of course, control the service insurance corporation it creates under ch. 613, but the service insurance corporation will be legally separate. This will lead to more effective (and appropriate) control by the insurance commissioner, who should neither be empowered nor compelled, as arguably he was under the old statutes, to have any concern about the purely professional activities of the societies, because of the impossibility of disentangling the insurance and professional activities carried on by a single corporation.

SECTION 4. 182.032 of the statutes is repealed.

NOTE: Section 182.032 provides an elaborate framework for the organization of hospital service corporations. The location in ch. 182 makes no sense, for that is the chapter dealing with miscellaneous corporations having no other home in the statute book. These corporations have a special chapter, the new ch. 613 created by this proposal. That is where the provisions of s. 182.032 belong, so far as they are to be retained.

Section 182.032 (2) (a) through (e) authorizes a particular form of organization that is allowed by ch. 613, but without precluding other models as does s. 182.032.

Section 182.032 (2) (f) is continued, mostly in s. 628.37, with a small part in s. 632.86.

Section 182.032 (3) provides much detail for the articles of a hospital service corporation. The detail is objectionable because it is not necessary for a sound operation, and more flexibility should be permitted, as it is under ch. 613. Sub. (3) (c) restricted contracts with policyholders (subscribers) to hospital services and health care. The restriction is generally sound but not invariably necessary, and need not be incorporated in the statutes. Sub. (3) (c) also preserves freedom of choice to the policyholder; that part is continued in s. 632.86.

Section 182.032 (3) (d) specifies what law is applicable. That is done by ss. 613.02 (1) (b) and 613.03.

Section 182.032 (4) prevents contracts with policyholders (subscribers) until there is a minimum number of contracts with hospitals as providers. The notion is sound, but an arbitrary limit may prevent the organization of sound but small local corporations. The commissioner has adequate power under ch. 613 to prevent unsound organizations; he needs more flexibility than sub. (4) permits to allow experimentation, with the development of health maintenance organizations (HMO's), for example.

Section 182.032 (5) in part specifies applicable law. See comment on sub. (3) (d) above. In part it provided a tax exemption and an exemption from ch. 108 (unemployment compensation). The tax exemption is continued in s. 613.81; the unemployment compensation exemption is discontinued by the treatment of section 108.02 (4) (d). See note on that section.

Section 182.032 (6) limits nonprofit hospital service plans to those organized under s. 182.032. A corresponding limitation is continued under ch. 613. It also prevents participating hospitals from contracting with 2 such corporations. There is no sound reason for the restriction and it is omitted from ch. 613. Section 628.35 prohibits exclusive contracts.

Section 182.032 (7) protects participating hospitals from liability for default of the corporation or of other participating hospitals. It may not be necessary but is continued in s. 613.90.

SECTION 5. 200.26 of the statutes is repealed.

NOTE: Section 200.26 is the section governing certain aspects of the regulation of nonprofit service plans. Section 200.26 (3) is retained in s. 613.08. The other subsections of s. 200.26 are replaced by ch. 613 in general and the supplementary provisions from other chapters contained in this proposal.

SECTION 6. 201.045 (1) of the statutes is amended to read:

201.045 (1) SCOPE. This section applies to all insurers incorporated or organized under any law of this state except chs. 611 and 612, and to nonprofit service plans as defined by s. 200.26 and 613.

NOTE: The change in s. 201.045 (1) is a technical correction.

SECTION 7. 204.321 (2) (d) of the statutes is repealed.

NOTE: Section 204.321 (2) (d), along with a related section (s. 200.26 (6)) is continued in s. 632.89, created by this act.

SECTION 8. 204.323 of the statutes is repealed.

NOTE: Section 204.323 is continued in substance in s. 632.90, created by this act.

SECTION 9. 207.04 (1) (k) of the statutes is repealed.

NOTE: Section 207.04 (1) (k) is continued in altered form in s. 632.87. See note on that section.

SECTION 10. 207.04 (1) (m) of the statutes is amended to read:

207.04 (1) (m) *Refusing choice of chiropractic services.* Refusing to offer inclusion of coverage for services of chiropractors or physicians, as defined in s. 990.01 (28), lawfully rendered in this state when writing a policy providing accident and health benefits for treatment encompassing such services, if the policy provides payment for services performed by such a physician or chiropractor, all at the option of the assured, including policies ~~under plans under s. 148.03 (1)~~ issued by service insurance corporations organized under ch. 613 pursuant to s. 148.03.

SECTION 11. 209.04 (11) of the statutes is repealed.

NOTE: Section 209.04 (11) is replaced by s. 628.22 in much simpler form.

SECTION 12. 209.047 of the statutes is amended to read:

209.047 Agent defined. Every person who solicits, negotiates or effects insurance of any kind, including annuities, on behalf of any insurance company, ~~nonprofit service plan as defined by s. 200.26~~ service insurance corporation under ch. 613, or person desiring insurance, or transmits an application for a policy of insurance or an annuity contract, other than for himself, to and from any such company, or who makes or proposes to make any contract for insurance or annuities, or who collects any premium, assessment, fees or dues for insurance or annuities or in any manner aids or assists in doing either, or in transacting any business of like nature for any insurance company, ~~or nonprofit service plan as defined by s. 200.26~~ service insurance corporation under ch. 613 or advertises to do any such thing, or who makes or proposes to make, as guarantors or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety shall be held to be an agent of such insurer to all intents and purposes, unless it can be shown that he receives no compensation for such services. The term "agent" shall not include any regular salaried officer or employe of a licensed insurer or of a licensed insurance agent who does not solicit or accept applications from the public for any such contract. A regular salaried officer or employe of an insurer authorized to do business in this state shall not be deemed to be an "agent" by reason of rendering assistance to or on behalf of a licensed agent, ~~provided that if~~ such salaried officer or employe devotes substantially all of his time to activities other than the solicitation of applications for insurance or annuity contracts and receives no commission or other compensation directly dependent upon the amount of business obtained. The term "agent" shall not include the attorney in fact of a reciprocal or interinsurance exchange, nor the traveling salaried home office representatives of such an exchange operating on a salary basis and receiving no commissions, but shall include every person who solicits, negotiates or effects insurance on behalf of such an exchange as an appointed agent on a commission basis.

SECTION 13. 447.13 of the statutes is repealed and recreated to read:

447.13 Service insurance corporations for dental care. The state dental society or, in a manner and to the extent approved by the state society, a county or district society, may establish in one or more counties in this state a service insurance corporation for dental care under ch. 613.

SECTION 14. 449.15 of the statutes is repealed and recreated to read:

449.15 Service insurance corporations for optometric care. The Wisconsin vision services, incorporated, may establish a service insurance corporation for optometric care under ch. 613.

SECTION 15. 450.13 of the statutes is repealed and recreated to read:

450.13 Service insurance corporations for pharmaceutical services. The Wisconsin pharmaceutical association may establish a service insurance corporation for pharmaceutical services under ch. 613.

SECTION 16. 600.03 (6) of the statutes is amended to read:

600.03 (6) "Business plan" means the aggregate of the information that ~~would have to~~ must be supplied to the commissioner under s. 611.13 (2) (j) and (k) ~~if the corporation were seeking to organize under ch. 611 or 613.13 (1) (i) and (j).~~

SECTION 17. 600.03 (33) of the statutes is repealed.

SECTION 18. 600.03 (41m) of the statutes is created to read:

600.03 (41m) "Service insurance corporation" means any corporation organized or operating under ch. 613.

SECTION 19. 601.31 (25) and (26) of the statutes are amended to read:

601.31 (25) Town mutual insurance companies, voluntary nonprofit sickness care plans organized under s. 185.981 and interscholastic benefit plans organized under s. 185.991 are exempt from all provisions of this section except subs. (19) and (21). Mutual benefit societies are subject to this section except they are exempt from subs. (2), (3), (10), (11), (12), (13), (15), (16) and (17). ~~Nonprofit service plans, as defined by s. 200.26, are subject to this section.~~

(26) For the purposes of this section "domestic company" means any authorized insurer incorporated or organized under any law of this state including mutual benefit societies and ~~nonprofit service plans as defined by s. 200.26~~ service insurance corporations under ch. 613; "foreign company" means any insurer incorporated or organized under the laws of any state including mutual benefit societies; and "alien company" means any insurer incorporated or organized under the laws of any foreign nation, or of any province or territory not included under the definition of foreign company. "State" means any state of the United States, the government of Puerto Rico and the District of Columbia.

SECTION 20. 610.46 of the statutes is created to read:

610.46 Transition provision for service insurance corporations. (1) EFFECTIVE DATE OF CHAPTER 613. Except as otherwise provided in subs. (2) and (3), ch. 613 is effective on the day after publication.

(2) EXISTING NONPROFIT SERVICE PLANS. (a) *Authorization.* Nonprofit sickness care plans under s. 148.03, 1973 stats., nonprofit hospital service corporations under s. 182.032, 1973 stats., nonprofit dental care plans under s. 447.13, 1973 stats., nonprofit optometric care plans under s. 449.15, 1973 stats., and nonprofit pharmaceutical service plans or prepaid prescription plans under s. 450.13, 1973 stats., which, prior to the effective date of this act (1975), have filed with the commissioner the information required in s. 200.26 (2), 1973 stats., and otherwise complied with s. 200.26 (3) and (6) and the sections referred to in s. 200.26 (4), 1973 stats., continue to be authorized under s. 613.13, subject to pars. (c) and (d), and shall be regulated under ss. 148.03, 182.032, 447.13, 449.15 or 450.13, 1973 stats., and s. 200.26, 1973 stats., until each becomes fully subject to ch. 613.

(b) *Incorporated plans.* Sections 613.11 to 613.13 do not apply to incorporated nonprofit service plans authorized under par. (a), except that the commissioner may

by order require any information that would be required under s. 613.13 if it were applicable.

(c) *Incorporation.* An unincorporated nonprofit service plan satisfying par. (a) may incorporate under ss. 613.11 to 613.13 at any time within one year after the effective date of this act (1975), and if it complies is exempt from payment of any fees under s. 601.31 that are otherwise payable at the time of incorporation and obtaining of an initial certificate of authority. The commissioner may by order exempt any such plan from any portion of the requirements of ss. 613.11 to 613.13. Until incorporation, those provisions of ch. 613 that are appropriate only for a corporation do not apply. After incorporation, a plan shall not be subject to s. 611.28, pursuant to s. 613.20, if it has transacted a substantial insurance business for the 5 years immediately preceding incorporation. Any plan that has not incorporated one year after the effective date of this act (1975) shall become a corporation on that date by operation of law. The commissioner shall thereupon issue an order requiring the new corporation to comply with such portions of the requirements of ss. 613.11 to 613.13 as he considers to be necessary for effective operation as a corporation under ch. 613.

(d) *Delayed effect of ch. 613.* Except as they become applicable sooner by incorporation under par. (c), ss. 613.19, 623.11 and 623.12 apply to nonprofit service plans satisfying par. (a) one year after the effective date of this act (1975). Any such nonprofit service plan may elect to comply with ss. 613.19, 623.11 and 623.12 at an earlier date.

(e) *Extension of business.* No nonprofit service plan may extend its business beyond that described by the information filed under s. 200.26 (2), 1973 stats., prior to the effective date of this act (1975), unless it applies for a certificate of authority, which shall be issued upon substantial compliance with the procedural and substantive requirements of s. 613.13, including incorporation if the plan is not yet incorporated.

(3) EXTENSION OF ADJUSTMENT PERIOD. If timely adjustment to the requirements of ch. 613 would cause a previously authorized plan hardship, disproportionate expense or serious inconvenience, the commissioner may, upon the plan's request, grant an additional delay for compliance with specified requirements if the interests of insureds and of the public are not endangered. In addition, if the commissioner is satisfied that a previously authorized unincorporated plan has not incorporated because it has been unable, despite its good faith and timely efforts, to obtain for the corporation into which it would incorporate the exemption from federal income tax under section 501 of the federal internal revenue code of 1954, as amended, that the plan then has, the commissioner shall, upon the plan's request, grant an additional delay for the plan to incorporate under ch. 613. If the delay granted is for more than 2 years beyond the effective dates otherwise applicable, the commissioner shall include in each annual report under s. 601.46 (3), until the requirements are fully effective, a detailed statement of the delay granted and the reasons therefor.

NOTE: This SECTION provides the necessary transitional provisions for making ch. 613 effective. The provisions for delay and waiver of fees in compliance minimize the cost of incorporation.

SECTION 21. 610.47 of the statutes is amended to read:

610.47 Transition provisions for miscellaneous unincorporated insurers. Except for ~~nonprofit service plans under s. 200.26 or~~ associations under ss. 185.981 and 185.991, and except as otherwise provided in this code, all unincorporated domestic insurance associations, societies or organizations shall be reorganized as corporations under ch. 202, 208 or 611 before January 1, 1973, or the commissioner shall thereupon petition for and the court shall forthwith issue an order for liquidation under s. 645.42 on the ground of failure to incorporate as here required.

SECTION 22. Chapter 613 of the statutes is created to read:

CHAPTER 613

SERVICE INSURANCE CORPORATIONS

PREFATORY NOTE: The following is a table of contents of chapter 613:

SUBCHAPTER I

GENERAL PROVISIONS

- 613.01 Definitions.
- 613.02 Scope and purposes.
- 613.03 Applicability of chapters 180, 181 and 611.
- 613.04 Orders imposing and eliminating restrictions.
- 613.07 General corporate powers and procedures.
- 613.08 Filing of contract forms.

SUBCHAPTER II

ORGANIZATION OF CORPORATIONS

- 613.10 Reserved name.
- 613.11 Incorporators.
- 613.12 Articles and bylaws.
- 613.13 Certificate of incorporation and authority.
- 613.19 Financial and contractual resources.
- 613.20 Alteration of certificate of authority.
- 613.24 Segregated asset and special accounts.
- 613.26 Subsidiaries.
- 613.28 Changes in business plan.
- 613.29 Amendment of articles.

SUBCHAPTER III

SECURITIES OF SERVICE INSURANCE CORPORATIONS

- 613.31 Securities regulation.
- 613.33 Authorized securities.

SUBCHAPTER IV

MANAGEMENT OF CORPORATIONS

- 613.40 Members and meetings.
- 613.41 Communications to members of policyholders and attendance at meetings.
- 613.51 Board of directors.
- 613.52 Officers.
- 613.53 Policyholder or public members of board of directors.
- 613.54 Supervision of management changes.
- 613.55 Continuity of management in emergencies.
- 613.56 Committees of directors.
- 613.57 Interlocking directorates and other relationships.
- 613.58 Policyholders' committee.
- 613.60 Transactions in which directors and others are interested.
- 613.62 Directors' liability and indemnification.
- 613.63 Executive compensation.
- 613.66 Exclusive agency contracts.
- 613.67 Management contracts.
- 613.69 Dividends and other distributions.

SUBCHAPTER V

REORGANIZATION OF CORPORATIONS

- 613.72 Merger and consolidation of service insurance corporations.
- 613.74 Voluntary dissolution of solvent service insurance corporations.
- 613.75 Conversion of a service insurance corporation into a stock or mutual insurance corporation.
- 613.78 Transfer of business or assets.

SUBCHAPTER VI

SUPPLEMENTARY PROVISIONS

- 613.80 Hospital service insurance corporations (policy statement).
- 613.81 Tax exemption for hospital service insurance corporations.
- 613.90 Vicarious liability.
- 613.92 Administrative agent.

Summary of recommendations. This chapter provides a general legislative framework for the organization, operation and regulation of a class of insurance enterprises sometimes known as "nonprofit service plans". The best known are the Blue Cross and Blue Shield plans for providing hospital, medical and surgical care.

The commissioner regulates these corporations under a group of diverse and scattered statutes: a set of general powers in s. 200.26, sub. (4) of which gives the commissioner his most important regulatory powers over them by subjecting them to particular provisions of the statutes, and 5 individual legislative enabling acts scattered throughout the statute book, authorizing formation of 5 different kinds of nonprofit service plans. Some of the enabling acts have fairly detailed provisions.

Nonprofit service plans (here called "service insurance corporations") contribute to a healthy and competitive insurance market. They represent a useful form of insurance organization; they should be encouraged to organize, given room to experiment and an opportunity to compete. In particular, various types of health maintenance organizations should be encouraged.

Chapter 613 contains some general rules which permit providers of services of any kind to set up nonprofit service insurance corporations, similar in many respects to ordinary cooperatives under ch. 185, but in which policyholders would have no control. Such corporations are in fact producers' cooperatives, although the corporations themselves are nonprofit and may have motives directed toward the welfare of the public. Often they clearly do. This proposal calls such organizations "service insurance corporations". A more complete title, not used here, would be "providers' service insurance corporations". A natural abbreviation, "service corporations", is avoided to prevent confusion with corporations thus titled under s. 180.99.

Some existing nonprofit service plans are unincorporated. They have generally operated successfully without incorporation and there is no absolute necessity for them to be incorporated. However, the law of unincorporated associations is poorly developed, and therefore is less precise and less satisfactory than corporation law. There is much to be gained at very little cost by requiring all such organizations, both new and already organized, to be corporate in form. It makes it possible to be much more certain what the available assets are, who is liable for what and entitled to what, what procedures are to be followed in making decisions when questions are raised about procedures, and how any organization in difficulty can be rehabilitated

or, if necessary, liquidated. Thus, all such plans should be required to incorporate within a reasonable time. No serious burden is cast on them. The opponents of incorporation have not given any persuasive reasons for their position. They mention the benefits of close association with and free services by the professional associations and their members. None of that needs to be lost. They mention innovation, which is no monopoly of unincorporated associations. They urge cost, but without providing any figures, even rough ones. The plans would incorporate under ch. 613, but would be subject for most purposes to the law of ch. 181, as this proposal provides. Cost has been minimized under the terms of s. 610.46.

Preferred tax treatment

The consolidation and generalization of the 5 special enabling statutes is not intended to affect the preferred tax treatment given to hospital care plans by s. 182.032 (5), nor any other tax advantage enjoyed by service plans. The tax exemption of s. 182.032 (5) is specifically continued in this proposal, without suggesting any position about its merits.

Other nonprofit service corporations are treated by this proposal in exactly the same manner as the hospital care plans, i.e., the tax law is left alone.

The more general question of the best way to distribute health care and the full implications of the role of service corporations in that field, especially in view of their large share of the market and of the rapidly escalating and seemingly uncontrollable cost of medical and hospital services, is far beyond the scope of this revision. The problem of health care in all its aspects is one that deserves a special study and legislative proposal by persons especially expert in these problems. It is much broader than an insurance matter and this proposal only deals with its insurance aspects. This proposal does not seek to extend the powers of the insurance commissioner to deal with medical and hospital costs. It is doubtful if the commissioner is the right official for such a task.

Development of nonprofit service plans

In contrast to many attempts to sell services through a plan resembling insurance, the "nonprofit service plans" of s. 200.26 are based on specific enabling legislation secured through the efforts of professional associations and other groups.

Medical service plans of the kind formerly described in s. 148.03 were first authorized by ch. 350, laws of 1935. Hospital service plans were permitted by ch. 118, laws of 1939 (later s. 182.032). The 2 classical types of service organizations organized thereunder, also known as Blue Cross (hospital care) and Blue Shield (surgical services), were subjected to increased control by the insurance commissioner by ch. 602, laws of 1959, which created s. 200.26.

Thereafter, 3 more types of professional service organizations were authorized: dental service plans by ch. 400, laws of 1961 (creating s. 152.53, now s. 447.13), pharmaceutical service plans by ch. 314, laws of 1963 (creating s. 151.17, now s. 450.13), and optometric service plans by ch. 73, laws of 1967 (creating s. 153.15, now s. 449.15). They are all alike subjected to s. 200.26, thus ensuring a substantial amount of meaningful insurance regulation, differing little from the regulation of commercial insurers.

The future of nonprofit service plans

The development of service plans need not stop at its present reach. The legislature will hardly be able to deny to other professional and business groups the privileges already granted hospitals, physicians, dentists, pharmacists and optometrists. Nor should it. If the plans proposed are sound they should be authorized. Services for which enabling legislation might be suggested within the next few years include the following:

Sanitarium care — now excluded from Blue Cross contracts.

Blood and tissue transfer services — see s. 146.31 and Blood Service Plans Ins. Co. v. Williams, 186 So. 2d 33 (Fla. 1966).

Home Nursing Services — not covered by Blue Cross contracts.

Psychiatric services — not covered by Blue Cross or Blue Shield.

Ambulance services — authorized and regulated in Florida (ch. 638, enacted 1961).

Life care contracts — offered by nursing homes and regulated in Florida (ch. 651, enacted 1953).

Funeral services — authorized and regulated in other states.

Cemetery services.

Veterinary services — see s. 201.04 (14).

Legal services — a future development now being experimented with in some places in the United States. It is commercially available on a limited basis, and may grow rapidly if it proves economically feasible.

There is no reason to restrict the concept of service insurance to health care or other professional or quasi-professional services. There are also some purely commercial services which might be marketed profitably on an insurance plan of an organization set up and controlled by the providers of the services. Examples include the following:

Auto repair and related services.

Car replacement services.

Boat repair services.

TV, stereo and other electronic repair services.

Plumbing services.

Home repair and reconstruction services.

All these services are related to the contingency of damage, destruction or other loss and are therefore a proper subject for insurance coverage. At present, some insurers offer indemnity for the expenses incurred in obtaining most such services under some limited circumstances. But an insurance business geared to providing services rather than indemnity might be operated at lower cost and therefore more profitably or at lower rates and more broadly than the traditional indemnity insurance. For example, it would be natural and might be very desirable for automobile insurers to set up chains of repair shops, or conversely, for repair shops to organize a service insurance program.

Apart from possible antitrust considerations not directly related to insurance law, there is no public policy against any such operation, provided it is adequately supervised and the interests of policyholders are sufficiently protected. The regulatory problems presented by any form of service insurance are basically similar to one another and somewhat different from

those of indemnity insurance, sometimes calling for a closer surveillance of the benefits promised and their actual costs, and sometimes requiring a different financial structure.

Systematic treatment of service plans

Instead of continuing the practice of enacting special enabling legislation each time a demand for authorization of a new kind of service insurance is pressed, it is appropriate, in the context of the comprehensive revision of the insurance laws ordered by s. 13.84, to consolidate and generalize existing legislation into a set of rules under which all insurers of this kind, existing and future, can be accommodated. This approach is more equitable to the diverse interests involved, more efficient and more understandable as a legislative scheme.

As regards substantive regulation, nonprofit service plans are already integrated into the system by s. 200.26. They must obtain a license and submit annual statements to the insurance commissioner, their contract forms are subject to approval, their reserves and investments are prescribed by statute, and they are examined as are all other insurers.

The organization of the chapter

This chapter incorporates by reference extensively from chapter 181 on nonprofit corporations. Chapter 181 is better suited to service insurers than ch. 180, which contemplates the making of profits by the corporation itself, or than ch. 185 which was tailored mainly to serve the needs of agricultural cooperatives. This draft also incorporates by reference from ch. 611 on domestic insurance corporations. The incorporation of both chapters is spread throughout the chapter, in order better to preserve the organization and usability of the proposal. As between brevity and ease of reference, the latter has been generally favored, though not exclusively.

SUBCHAPTER I

GENERAL PROVISIONS

613.01 Definitions. In this chapter, unless the context requires otherwise:

(1) ARTICLES OF INCORPORATION. "Articles of incorporation" has the meaning designated under s. 181.02 (5).

(2) BOARD OF DIRECTORS. "Board of directors" has the meaning designated under s. 181.02 (8).

(3) BY-LAWS. "By-laws" has the meaning designated under s. 181.02 (6).

(4) NONPROFIT CORPORATION. "Nonprofit corporation" has the meaning designated under s. 181.02 (4).

(5) NONSTOCK CORPORATION. "Nonstock corporation" has the meaning designated under s. 181.02 (3).

(6) SECRETARY OF STATE. In any provision of ch. 180 or 181 made applicable to service insurance corporations in this chapter, "secretary of state" means commissioner of insurance.

(7) INSURER. In any provision of the statutes made applicable to service insurance corporations by this chapter, "insurer" includes service insurance corporations, and the technical terms used in those statutes shall be applicable to service insurance corporations despite the customary use of other parallel terms by service insurance corporations.

NOTE: It does not now appear that many special definitions are needed for this chapter. The word "policyholder" is defined in s. 600.03 (37)

broadly enough to cover the “subscriber” of nonprofit service plans. “Insured” is defined in s. 600.03 (26) to include subscribers and beneficiaries. “Subscriber” is a term on which nonprofit service plans have often insisted in an effort to distinguish themselves from ordinary insurers. But while it is unobjectionable as a term for use in the contracts and literature of the plans, it is unnecessarily complicating in the statutes, and the word “policyholder” is preferable and is used in this proposal. So likewise is “insured” preferable to “beneficiary” as a statutory term comprehending both policyholders and other insureds (or subscribers and other beneficiaries).

Application of s. 181.02 (4) to service insurance corporations of course does not prevent them from paying otherwise appropriate salaries to their officers.

Sub. (7) makes terms such as “policyholders”, “policy” and the like apply to the “subscriber”, the “contract” issued by the service corporation, and so forth. The translation of terms should present no problems in practice.

613.02 Scope and purposes. (1) **SCOPE.** (a) This chapter applies only to corporations incorporated under the laws of this state. Corporations not incorporated under the laws of this state may not do business in this state under this chapter.

(b) Except as otherwise specifically provided, service insurance corporations organized or operating under this chapter are subject to ss. 204.315, 204.335, 209.04, 610.46, 632.86, 632.87, 632.89 and 632.90 and chs. 207, 600, 601, 617, 620, 625 and 645 and to no other insurance laws.

(2) **PURPOSES.** The purposes of this chapter are:

(a) To create an effective and flexible legal framework within which insured service benefits may be provided with adequate protection to consumers;

(b) To encourage innovation in insurance organization and marketing and the development of more economical and effective ways of providing services or combinations of indemnity and services;

(c) To meet the special needs of service insurance corporations consistent so far as possible with the general framework of the corporation law of insurance; and

(d) To ease the burden of payment for health care and other essential services by providing a method for creating alternative vehicles for providing them.

NOTE: Sub. (1) (a) prevents admission of nondomestic service insurance corporations. If interstate operation is contemplated, the stock or mutual corporate form of chs. 611 and 618 seems preferable.

Sub. (1) (b) subjects these corporations to applicable portions of the insurance code by listing the specific chapters and sections that are applicable.

Sub. (2) seeks to formulate the purposes of these corporations to assist in interpreting substantive provisions. They do not constitute a separate source of regulatory power. See s. 600.12.

Sub. (2) (d) is taken from s. 182.032 (1) but is broadened beyond hospital services to include all health care and other essential services. The advance of medical technology and the changing economics of health care have made the burden of such services extremely heavy even for the affluent; for the lower strata of the population the burden is oppressive. As the legislature said in s. 182.032 (1), “the payment for adequate hospital services is a pressing problem with grave social ramifications.” That statement is even more clearly true now than when the legislature first enunciated it. It

follows that much experimentation in methods of financing and distributing the cost of health care is needed: innovations in commercial insurance, expansion of providers' service plans such as the nonprofit service plans of the "Blues", cooperative sickness care plans under s. 185.981, prepayment plans, HMO's and other even yet uninveted devices should all be tried. All experiments that give hope of solving health care problems without burdening the public treasury and of contributing to the solution of the pressing social and economic problem of providing quality health care for all Wisconsin citizens merit support. The financial health of hospitals is socially important so that they can provide free or below-cost services to those portions of the population whose economic status falls so low that they cannot afford adequate services. The Articles of Incorporation of Associated Hospital Service, Inc., says that one of its purposes is "to provide for the sickness care of indigents and low income groups..." Its performance of that laudable objective should be encouraged and facilitated, although it would probably be unreasonable actually to require it, except perhaps to the extent that it is the justification for favorable treatment for taxation or other purposes.

613.03 Applicability of chapters 181 and 611 to service insurance corporations. (1) CHAPTERS 181 AND 611 GENERALLY INAPPLICABLE TO SERVICE INSURANCE CORPORATIONS. Chapters 181 and 611 do not apply to service insurance corporations except as specifically made applicable by this chapter.

(2) INSURANCE CORPORATION LAW. Whenever in this chapter a section, subsection or paragraph of ch. 611 is made applicable to service insurance corporations the application shall be of those portions of the section, subsection or paragraph of ch. 611 that apply to mutual corporations.

NOTE: The structure of chs. 611 and 613 is the same, and some sections of ch. 611 are incorporated by reference. Some sections of ch. 181 are also incorporated by reference, in places logical in terms of the structure of ch. 613, but not necessarily in the sequence of ch. 181.

613.04 Orders imposing and eliminating restrictions. (1) ORDERS IMPOSING RESTRICTIONS. The commissioner may subject an individual corporation not otherwise subject thereto to some or all of the restrictions of ss. 613.28, 613.33 (1) (a) and (b) and 611.54 (1) (b) as incorporated by s. 613.54, if he finds that its financial condition, management or other circumstance requires such additional regulation for the protection of the interests of insureds or the public.

(2) ORDERS ELIMINATING RESTRICTIONS. The commissioner may free a new corporation from any of the restrictions generally applicable only to new corporations under ss. 613.28, 613.33 (1) (a) and (b) and 611.54 (1) (b) as incorporated by s. 613.54, if he is satisfied that its financial condition, management or other circumstance gives assurance that the interests of insureds and the public will not be endangered thereby.

NOTE: This is parallel in form to s. 611.03, but the sections to which it refers are fewer. Sub. (2) would in normal course be applied to any unincorporated association in sound condition as soon as it is incorporated under s. 610.46 (2) (c).

613.07 General corporate powers and procedures. (1) POWERS. Service insurance corporations have the powers specified under s. 181.04 (1) to (12), (14) and (16).

(2) ULTRA VIRES. Section 181.05 applies to service insurance corporations.

(3) OMISSION OF SEAL. Section 181.665 applies to service insurance corporations.

(4) WAIVER OF NOTICE AND INFORMAL ACTION BY SHAREHOLDERS OR DIRECTORS. Sections 181.70 and 181.72 apply to service insurance corporations.

613.08 Filing of contract forms. (1) All forms of contracts, riders, endorsements, applications, notices of proposed contracts or other instruments which a service insurance corporation proposes to issue as a 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 of the contract unless the rate is unfairly discriminatory. The rate for a contract may reflect a differential attributable to the number of persons covered, actuarial experience or plan of operation under which the contract is issued without being considered unfairly discriminatory.

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

(3) The commissioner may within 30 days after the filing of any such form disapprove the form if it contains a provision that is unjust, unfair, inequitable, misleading, deceptive or encourages misrepresentation of the contract. Any such provision filed after January 1, 1976, which provides coverage for hospital care but does not provide coverage for at least 30 days for skilled nursing care to patients upon transfer within 24 hours from a general hospital to a licensed skilled nursing home at a daily rate which does not exceed the daily rate established for such home by the department of health and social services, is deemed to be unjust, unfair and inequitable. Such skilled nursing care shall be certified as medically necessary by the attending physician and recertified as medically necessary every 7 days, shall not be domiciliary or custodial, shall be continued treatment for the same medical or surgical condition for which the patient had been treated at the hospital and shall not be available to the patient without charge or under a government health care program. Any such provision for physician's services but not for podiatric services shall be deemed unjust, unfair and inequitable. If the commissioner notifies the corporation that the form does not comply with this subsection, the corporation may not thereafter issue or use the form. In such notice the commissioner shall specify the reason for his disapproval and state that upon request in writing by the corporation a hearing will be granted within 20 days.

(4) The commissioner may at any time, after a hearing on not less than 20 days' written notice to the corporation, withdraw his approval of any such form on any ground under sub. (3). The corporation may not issue the form or use it after the effective date of the withdrawal of approval.

NOTE: This section replaces s. 200.26 (3).

SUBCHAPTER II

ORGANIZATION OF CORPORATIONS

613.10 Reserved name. A service insurance corporation may reserve a corporate name as provided in s. 181.07.

613.11 Incorporators. Any number of corporate or adult natural persons may organize a service insurance corporation under s. 613.13.

NOTE: This section parallels s. 611.11 (1).

613.12 Articles and bylaws. (1) **CONTENTS OF ARTICLES.** The articles of a service insurance corporation shall conform to s. 181.31, except that:

(a) The name of the corporation shall include descriptive terms to indicate the general nature of the services or care to be provided, or a trade name that is generally understood as indicating such service or care, and shall comply with s. 181.06 (3);

(b) The purposes of the corporation shall be limited to those permitted in s. 610.21;

(c) The services to be provided or for which indemnity is to be paid shall be generally described and shall be of the same kind as the services ordinarily provided by any members of the corporation in their profession or business, or of the persons entitled to designate members, and services ancillary thereto;

(d) The articles shall state whether members or other providers of services are subject to assessments for the purpose of paying operating costs or financial deficits, the general conditions and procedures for levying such assessments and any limitations on the assessments that may be levied;

(e) The articles shall state, for corporations having members, how persons may become members and that only members may vote; and

(f) The articles of a corporation not having members shall state how the directors of the corporation shall be selected.

(2) **BYLAWS.** The bylaws of a service insurance corporation shall comply with this chapter, and with all except the first sentence of s. 181.13. A copy of any amendments to the bylaws shall be filed with the commissioner within 60 days after adoption.

(3) **PRINCIPAL OFFICERS.** The articles or bylaws shall specifically designate 3 or more offices, the holders of which shall be the principal officers of the corporation. The principal offices shall be held by at least 3 separate natural persons.

NOTE: Sub. (1) roughly parallels s. 611.12 (2) and subs. (2) and (3) are closely parallel to s. 611.12 (4) and (3). Under sub. (1) (c) and (e) it is permissible for a service insurance corporation to provide services by nonmembers as well as by members. Thus a medical services corporation whose members are physicians can supply services of other health care professionals or institutions as well as of physicians. It is also permissible for the ch. 613 corporations to have no members, as would be the case when a medical society is the incorporator. Its members may also be designees or representatives of providers, as under s. 182.032.

613.13 Certificate of incorporation and authority. (1) **APPLICATION.** The application for a certificate of incorporation and authority shall be signed and acknowledged by or on behalf of each incorporator, and shall include or have attached all of the following:

(a) The names, and for the preceding 10 years, all addresses and all occupations of all incorporators and proposed directors and officers.

(b) For all corporate incorporators, their articles and bylaws, a list of the names, addresses and occupations of all directors and principal officers, and for the 3 most recent years their annual financial statements and reports.

(c) The proposed articles which shall be signed and acknowledged by or on behalf of each incorporator, and the proposed bylaws.

(d) All agreements relating to the corporation to which any incorporator or proposed director or officer is a party.

(e) The amount and sources of the funds available for organization expenses and the proposed arrangements for reimbursement and compensation of incorporators or other persons.

(f) The proposed compensation of directors and officers.

(g) The forms to be used for any contracts between the corporation and its members or other persons concerning the provision of services to insureds.

(h) The proposed minimum permanent surplus, and the proposed initial expendable surplus.

(i) The plan for conducting the insurance business, including all of the following:

1. The geographical area in which business is intended to be done in the first 5 years.
2. The types of insurance intended to be written in the first 5 years including specification whether and to what extent indemnity rather than services are to be provided.
3. The proposed marketing methods.
4. To the extent requested by the commissioner, the proposed method for the establishment of premium rates and other charges to policyholders.

(j) A projection of the anticipated operating results of the corporation at the end of each of the first 5 years of operation, based on reasonable assumptions of loss experience, premium and other income, operating expenses and acquisition costs.

(k) Such other relevant documents or information as the commissioner reasonably requires.

(2) **ISSUANCE OF CERTIFICATE OF INCORPORATION AND AUTHORITY.** The commissioner shall issue a certificate of incorporation and authority if:

(a) He finds that all requirements of law have been met;

(b) He is satisfied that all natural persons who are incorporators, the directors and principal officers of corporate incorporators, and the proposed directors and officers of the corporation being formed are trustworthy and competent and collectively have the competence and experience to engage in the particular insurance business proposed; and

(c) He is satisfied that the business plan is consistent with the interests of the corporation's potential policyholders and of the public.

(3) **CONTENTS OF CERTIFICATE OF AUTHORITY.** The certificate of authority shall specify any limits placed on the insurance business that may be carried on by the corporation and may, within the powers given the commissioner by law, specify limits on its methods of operation.

(4) **LEGAL EXISTENCE.** Upon the issuance of the certificate of incorporation and authority the legal existence of the corporation shall begin, the articles and bylaws shall become effective and the proposed directors and officers shall take office. The certificate is conclusive evidence of compliance with this section, except in a proceeding by the state against the corporation.

NOTE: Sub. (1) follows closely the pattern of s. 611.13 (2). Sub. (2) follows the pattern of s. 611.13 (3). Sub. (3) follows s. 611.20 (2) (b). Sub. (4) tracks ss. 611.13 (5) and 611.22 (4), and adds the relevant portions of s. 181.33. The entire organizational procedure thus is a somewhat abbreviated version of that in ch. 611.

613.19 Financial and contractual resources. (1) **MINIMUM PERMANENT SURPLUS.** The commissioner shall specify a minimum permanent surplus for a corporation organized under this chapter. It shall be sufficient, in accordance with sound business practice, to provide for the needs of the proposed business, but shall not be less than \$50,000 nor more than \$2,000,000 except under sub. (5). In specifying the amount, the commissioner shall take into account all the information in the business plan including the projection supplied under s. 613.13 (1) (j), any contracts existing under sub. (3), the general economic situation, the reinsurance market available to the proposed corporation and any other factors relevant to its needs for surplus.

(2) **INITIAL EXPENDABLE SURPLUS.** A corporation organized under this chapter shall have an initial expendable surplus, after payment of all organizational expenses,

of at least 50% of the minimum permanent surplus specified under sub. (1), or such smaller percentage as the commissioner specifies.

(3) PROVIDERS' CONTRACTS. A service insurance corporation may make contracts with its members and other persons for the provision of services to policyholders in order to ensure performance of the insurance contracts to be issued. The selection of members and other providers with whom such contracts are made and the terms of the contracts, together with the surplus provided under subs. (1), (2) and (5), shall reflect the benefits and other terms provided in the insurance contracts and the number and distribution of existing and expected policyholders in such a way that it is reasonably to be expected that services will be provided as promised.

(4) ASSESSMENTS AGAINST POLICYHOLDERS. There may not be any assessments against policyholders.

(5) REDUCTION OF MINIMUM SURPLUS. The commissioner may reduce the minimum amounts of surplus required under subs. (1) and (2) if he finds, after a hearing under s. 601.62, that the extent and nature of providers' contracts under sub. (3), financial guarantees and other support by financially sound private or public corporations, a pressing social need in a particular community for the formation of a service insurance corporation, or other special circumstances, justify the proposed reduction in the required surplus.

NOTE: Four factors are of critical importance in determining the soundness of insurers under this chapter: (1) the contract defining the services to be provided and the policyholders' rights to demand the services; (2) the actual experience, i.e., the number, extent and distribution of claims; (3) the provisions the insurer has made for providing the services to satisfy such claims, whether through providers' contracts or through financial resources in the form of surplus; and (4) the skill and competence of management.

The third factor, which in ordinary indemnity insurance is exclusively a matter of money and financial resources, can develop (if actual cooperation of members is relied on), into an extremely complicated array of logistical problems since the claims must be discharged through performance by the providers of the services. This section gives the insurer an option to have contracts in effect with the providers of services so there will be reasonable assurance that the services will actually be available as promised, as an alternative to having adequate financial resources to ensure the performance. Because of the variety of services and benefits that can be promised to policyholders, and the many possible ways in which the availability of services may be ensured it is undesirable to specify this requirement more precisely in the statute.

So far as service obligations may be freely transformed by the insurer into indemnity obligations, and so far as an insurer issues contracts primarily providing indemnity, the problem of ascertaining the insurer's solidity is no different from that of any other insurer. Certain minimum financial resources must be available to make the operation viable and secure.

An insurer which exclusively or primarily provides services is less likely to become insolvent if there are appropriate contracts requiring the services to be rendered whether or not they are paid for. Such an operational plan of service insurance corporations gives policyholders an advantage over mere promises of money indemnity. Since they are entitled to specified services and the members or others under their contracts with the corporation are obligated to provide them, whether or not the premium receipts are sufficient

to pay for all money benefits, costs and services provided, the providers have to bear the eventual loss. Then there is less money to distribute among them. The arrangement may then be that the providers' claims are merely postponed and providers may not actually lose in the long run. This depends on the nature of the operation reflected in the articles and bylaws of the corporation. In that case, the claims of policyholders can be satisfied without a need to resort to cash surplus. Even if providers guarantee the service in the event that the nonprofit service plan lacks funds, there is still a risk of insolvency. The guarantee merely makes the provider the ultimate "risk-bearer", but there are natural limits to the provider's willingness and ability to provide services when funds are not available to pay him, and to the corporation's or policyholder's ability to force him to perform.

Nonprofit service plans may not have provider contracts with such guarantees, and some do not even use provider contracts. There is no problem in such a case, if there are substantial financial resources and a large operation.

A minimum permanent surplus or an equivalent financial guaranty becomes more important, however, when provider contracts are not used or when they are used without guarantees. In such cases, or when the commissioner has reason to expect that insureds may have difficulty in enforcing their claims for services against the individual providers, the danger of insolvency is more than theoretical. Instead of establishing a surplus for that purpose, the providers obligated to provide services could subject themselves to money assessments. Then the commissioner could dispense with a large permanent surplus, depending on the extent and collectibility of the assessment obligation. Such assessments would of course be of an entirely different nature than those levied by mutual insurance corporations, since they would not apply to insureds but to the owners of the insurer. The variety of possible arrangements requires that wide discretion be left to the commissioner under this section.

The initial expendable surplus required in sub. (2) is necessary under most circumstances to cover the high cost of transacting an insurance business during the early months of corporate life. It is required here just as it is required in s. 611.19 (4) (b) even for assessable mutuals, but the different and more complex nature of the problem makes more discretion in the commissioner important. A minimum of at least \$25,000 is required, in most cases but not in all. Some HMO's, for example, may have alternative arrangements that make cash surplus less important. Or else the pressing need of a community may make it important to take more risks. Sub. (5) provides adequate flexibility.

Sub. (3) permits a service insurance corporation to arrange to meet its obligations by substituting providers' contracts for a large part of the financial resources that would otherwise be essential.

Sub. (4) makes it clear that policyholders are entitled to get what they bargain for, without diminution, and not carry the risk for those who provide them services.

Sub. (5) makes it possible to experiment with HMO's and to permit the organization of socially necessary institutions in circumstances where the finding of sufficient cash presents problems. Such a concession should only be done publicly, by order after a public hearing, so there is substantial assurance that the concession is one that is socially justified. So far as insurance regulatory needs are concerned, this subsection, together with the

rest of this chapter, provides an adequate framework. There is some feeling that regulation of the health services aspect of HMO's is necessary. If so, it should not be cast as a part of insurance regulation, which has important goals, but not unlimited ones. The insurance mechanism is essentially a risk-spreading mechanism. That has important regulatory requirements, but should not be made a vehicle for the regulation of other substantive aspects of our society, such as the quality and cost of health services. This chapter facilitates the creation and financial control of HMO's; if there is need to regulate their substance, that should be the task of an agency other than the insurance commissioner. Conversely, however, no other agency should trench on effective financial control over HMO's by the insurance commissioner.

613.20 Alteration of certificate of authority. (1) UPON APPLICATION. A service insurance corporation may at any time apply to the commissioner for a new or amended certificate of authority, removing, altering or adding limits on its business or methods of operation. The application shall contain or be accompanied by so much of the information in s. 613.13 (1) as the commissioner requires. The commissioner shall issue the new certificate as requested if he finds that the:

(a) Corporation's surplus and providers' contracts are adequate to support the proposed operations under the new certificate; and

(b) Proposed business would not be contrary to the law or to the interests of insureds or the public.

(2) BY COMMISSIONER. If the commissioner issues a summary order under s. 645.21 against a corporation, he may also revoke the corporation's certificate and issue a new one with such limits as he deems necessary.

NOTE: This section parallels s. 611.20 (4).

613.24 Segregated asset and special accounts. Service insurance corporations are subject to ss. 611.24 and 611.25.

613.26 Subsidiaries. Service insurance corporations may act under s. 611.26.

613.28 Changes in business plan. Service insurance corporations are subject to s. 611.28.

613.29 Amendment of articles. (1) RIGHT TO AMEND ARTICLES. A service insurance corporation may amend its articles under ss. 181.35 to 181.37 and 181.39 in any desired respect including substantial changes of its original purposes not inconsistent with this chapter. No amendment may be made contrary to s. 613.12.

(2) FILING. For 5 years after the initial issuance of a certificate of authority, proposed amendments of the articles which are not changes in the business plan shall be filed with the commissioner at least 30 days before the amendment is submitted to the members for approval, or if such approval is not required, at least 30 days before the effective date. No amendment may become effective until the articles of amendment have been filed with the commissioner.

(3) EFFECT OF AMENDMENT. Section 181.41 applies to service insurance corporations.

NOTE: This follows generally s. 611.29. The rules of ch. 181 pertaining to amendment of articles are adopted except as slightly modified by this section.

SUBCHAPTER III
SECURITIES OF SERVICE INSURANCE CORPORATIONS

613.31 Securities regulation. (1) **REGISTRATION.** No securities issued by a service insurance corporation may be sold by or for the corporation unless they are registered or exempt from registration under ch. 551.

(2) **APPROVAL BY COMMISSIONER.** Securities of a service insurance corporation may not be registered under ch. 551 without prior approval of the commissioner of insurance.

NOTE: This section follows closely s. 611.31 (1) and (2).

613.33 Authorized securities. (1) **SERVICE INSURANCE CORPORATION BONDS.** The articles of a service insurance corporation may authorize service insurance corporation bonds of one or more classes and shall specify the amount of each class of bonds the corporation is authorized to issue, their designations, preferences, limitations, rates of interest, and relative rights, subject to all the following provisions:

(a) During the first year after the initial issuance of a certificate of authority, the corporation may issue only a single class of bonds with identical rights.

(b) After the first year but within 5 years after the initial issuance of a certificate of authority, additional classes of bonds may be authorized after approval of the commissioner, who shall approve if he finds that policyholders and prior bondholders will not be prejudiced.

(c) The rate of interest shall be fair and reasonable.

(d) The bonds shall bear a maturity date not later than 10 years from the date of issuance, when principal and accrued interest shall be due and payable, subject to sub. (4).

(2) **CONTRIBUTION NOTES.** Any service insurance corporation may issue contribution notes if the commissioner approves. He may approve only if he finds that:

(a) The notes will not be issued in denominations of less than \$500, and no single issue will be sold to more than 15 persons;

(b) No discount, commission or other fee will be paid or allowed;

(c) The notes will not be the subject of a public offering;

(d) Their terms are not prejudicial to policyholders, holders of service insurance corporation bonds or of prior contribution notes; and

(e) The corporation's articles and bylaws do not forbid their issuance.

(3) **PROHIBITED TRANSACTIONS.** No service insurance corporation may:

(a) If it has any outstanding obligations on service insurance corporation bonds or contribution notes, borrow on contribution notes from, or sell bonds to, any other insurer without approval of the commissioner; or

(b) Make any loan to another insurer except a fully secured loan at usual market rates of interest.

(4) **REPAYMENT.** Payment of the principal or interest on service insurance corporation bonds or contribution notes may be made in whole or in part only after approval by the commissioner. Approval shall be given if all financial requirements of the issuer to do the insurance business it is then doing will continue to be satisfied after payment and if the interests of its insureds and the public are not thereby endangered. In the event of liquidation under ch. 645, unpaid amounts of principal and interest on contribution notes shall be subordinated to the payment of principal and interest on any service insurance corporation bonds issued by the corporation at any time.

(5) **OTHER OBLIGATIONS.** Nothing in this section prevents a service insurance corporation from borrowing money on notes which are its general obligations, nor from pledging any part of its disposable assets therefor.

NOTE: This draft follows closely s. 611.33 as applied to mutuals. Although service insurance corporations are unlike mutuals in many respects because they are nonstock and (ordinarily) nonprofit corporations, they have similar financing problems.

SUBCHAPTER IV
MANAGEMENT OF CORPORATIONS

613.40 Members and meetings. In a service insurance corporation that has members:

(1) MEETINGS OF MEMBERS. Sections 181.14 and 181.15 apply to service insurance corporations.

(2) VOTING AND QUORUM. Sections 181.16 and 181.71 apply to service insurance corporations and s. 181.17 applies to service insurance corporations except as modified by ss. 613.72 (4) and 613.75 (2).

(3) DIVISION INTO DISTRICTS. Section 181.175 applies to service insurance corporations.

613.41 Communications to members or policyholders and attendance at meetings.

(1) COPIES OF COMMUNICATIONS. The commissioner may by rule prescribe that copies of specified classes of communications circulated generally by a corporation to members or policyholders shall be communicated to him at the same time.

(2) ATTENDANCE AT MEETINGS. The commissioner may attend any members' or policyholders' meeting.

NOTE: This closely parallels s. 611.41 (1) and (2).

613.51 Board of directors. (1) GENERAL. Section 181.18 applies to service insurance corporations.

(2) NUMBER, SELECTION AND CLASSIFICATION OF DIRECTORS. Section 611.51 (2) and the first sentence of s. 611.51 (5) apply to service insurance corporations. Sections 181.20 and 181.21 apply to service insurance corporations except as modified by ss. 613.53 and 613.54.

(3) INSIDE DIRECTORS. Employees and representatives of a service insurance corporation may not constitute a majority of its board.

(4) UNLAWFUL DELEGATION. The board shall manage the business and affairs of the corporation and may not delegate its power or responsibility to do so, except to the extent authorized by ss. 181.25 (2) and 613.56.

(5) QUORUM OF DIRECTORS. Section 181.22 applies to service insurance corporations, except as modified by s. 613.60.

(6) BOOKS AND RECORDS. Section 181.27 applies to service insurance corporations.

(7) PLACE AND NOTICE OF DIRECTORS' MEETINGS. Section 181.24 applies to service insurance corporations.

613.52 Officers. (1) GENERAL. Section 181.25 applies to service insurance corporations, as modified by s. 613.12 (3).

(2) REMOVAL. Section 181.26 applies to service insurance corporations.

613.53 Policyholder or public members of board of directors. The articles may provide that any number of the directors shall be chosen from among the policyholders, the general public or both, under a plan designed to assure independent directors truly representing the interests of policyholders or the public interest. The persons to be named as directors under this section shall be persons whose experience and existing

relationships qualify them to serve responsibly and impartially as independent policyholder or public directors.

NOTE: This permits policyholder or public representation on the board, as exists now in some organizations. If the organization is to be controlled by and operated in the interest of consumers, then it should be organized as a mutual under ch. 611, which is sufficiently flexible to permit organization of a corporation to supply services rather than pay indemnity. The provision for selection of public directors closely follows s. 611.53 (1).

613.54 Supervision of management changes. Section 611.54 applies to service insurance corporations.

613.55 Continuity of management in emergencies. Section 611.55 applies to service insurance corporations.

613.56 Committees of directors. (1) **APPOINTMENT.** If the articles or bylaws of a corporation so provide, the board by resolution adopted by a majority of the full board may designate one or more committees, each consisting of 3 or more directors serving thereon at the pleasure of the board. The board may designate one or more directors as alternate members of any committee to substitute for any absent member at any meeting of the committee. The designation of a committee and delegation of authority to it shall not relieve the board or any director of responsibility imposed upon it or him by law.

(2) **DELEGATION; MAJOR COMMITTEES.** When the board is not in session, a committee satisfying all of the requirements for the composition of a full board under s. 613.51 may exercise any of the powers of the board in the management of the business and affairs of the corporation, including action under s. 611.60 as applied to service insurance corporations by s. 613.60, to the extent authorized in the resolution or in the articles or bylaws.

(3) **DELEGATION; ORDINARY COMMITTEES.** When the board is not in session, a committee not satisfying the requirements of sub. (2) may exercise the powers of the board in the management of the business and affairs of the corporation to the extent authorized in the resolution or in the articles or bylaws, except action in respect to:

(a) Compensation or indemnification of any person who is a director, principal officer or one of the 3 most highly paid employees, and any benefits or payments requiring member or policyholder approval;

(b) Approval of any contract required to be approved by the board under s. 611.60 as applied to service insurance corporations by s. 613.60, or of any other transaction in which a director has a material interest adverse to the corporation;

(c) Amendment of the articles or bylaws;

(d) Merger or consolidation under s. 613.72, conversion under s. 613.75, voluntary dissolution under s. 613.74 or transfer of business or assets under s. 613.78;

(e) Any other decision requiring member or policyholder approval;

(f) Amendment or repeal of any action previously taken by the full board which by its terms is not subject to amendment or repeal by a committee;

(g) Dividends or other distributions to members or policyholders, other than in the routine implementation of policy determinations of the full board;

(h) Selection of principal officers; and

(i) Filling of vacancies on the board or any committee created under sub. (1) except that the articles or bylaws may provide for temporary appointments to fill vacancies on the board or any committee, the appointments to last no longer than the end of the next board meeting.

(4) **SUBSEQUENT REVIEW.** The full board or a major committee of the board authorized to do so under sub. (2) shall specifically review any transaction in which an officer has a material financial interest adverse to the corporation, at the next meeting following action by any ordinary committee.

NOTE: This section closely parallels s. 611.56.

613.57 Interlocking directorates and other relationships. Section 611.57 applies to service insurance corporations.

613.58 Policyholders' committee. A service insurance corporation's articles or bylaws may provide for a policyholders' committee, to be selected in a manner that will make its membership representative of the interests of policyholders. The policyholders' committee shall at the corporation's expense prepare an annual report to be filed with the commissioner. The corporation shall inform all policyholders of the availability of the report in a manner approved by the commissioner and shall send copies of the report to policyholders upon their request. A summary of the report prepared or approved by the committee and not exceeding 2,000 words shall be included with any annual report issued by the corporation to members or policyholders.

NOTE: This is new. It is intended to encourage policyholder participation.

613.60 Transactions in which directors and others are interested. Section 611.60 applies to service insurance corporations.

613.62 Directors' liability and indemnification. (1) **LIABILITY.** Section 181.29 applies to service insurance corporations.

(2) **INDEMNIFICATION.** Section 181.045 applies to service insurance corporations but no indemnification may be made until at least 30 days after notice to the commissioner, containing full details about the proposed indemnification.

(3) **INSURANCE.** Notwithstanding the limitations of subs. (1) and (2), a service insurance corporation may arrange and pay for lawful insurance on behalf of any person subject to subs. (1) and (2) against any liability incurred by him in connection with his service to the corporation, whether or not the corporation could lawfully indemnify him.

NOTE: This section closely parallels s. 611.62.

613.63 Executive compensation. (1) **ESTABLISHMENT OF COMPENSATION.** Section 181.19 applies to service insurance corporations, except as modified by ss. 613.60 and sub. (2).

(2) **RESTRICTIONS.** Sections 181.28 and 611.63 (3) to (5) apply to service insurance corporations.

613.66 Exclusive agency contracts. (1) **GENERAL.** Except under sub. (2), no service insurance corporation may enter into any contract whereby any person is granted the exclusive right or privilege of soliciting, producing or receiving a fee or commission on all or substantially all of the insurance business of the corporation in this state.

(2) **SUBSIDIARIES.** Subsection (1) does not apply to contracts in which a corporation is the exclusive agent of its insurance subsidiary authorized under s. 611.26 (1) as applied to service insurance corporations by s. 613.26, or in which the subsidiary is the exclusive agent of the corporation.

NOTE: This section closely parallels s. 611.66.

613.67 Management contracts. Section 611.67 applies to service insurance corporations.

613.69 Dividends and other distributions. (1) STOCK AND DIVIDENDS. Section 181.28 applies to service insurance corporations.

(2) NOTICE TO COMMISSIONER. No payments, other than the contractual compensation for services rendered to policyholders or payments to policyholders, officers and employes in the ordinary course of business, may be made to the members until 30 days after the proposed action has been reported to the commissioner.

NOTE: Although the danger of depletion of surplus by dividend payments may be less serious here than in the case of a stock corporation operating exclusively on an indemnity plan, this is untested ground. Therefore, it seems essential that the commissioner be kept informed of all distributions, as under s. 611.69. Distributing the profits resulting from an overcharge on policyholders may be regarded as in conflict with accepted rules of professional ethics in some instances but would be unobjectionable on that ground in at least the case of nonprofessional services.

SUBCHAPTER V

REORGANIZATION OF CORPORATIONS

613.72 Merger and consolidation of service insurance corporations. (1) AUTHORIZATION. Any 2 or more domestic service insurance corporations may merge or consolidate, if they provide services of the same or a related nature, or if the services complement one another or there are other reasons that make it reasonable for a single corporation to render both. A written plan of merger or consolidation shall be prepared, setting forth all the terms of the proposed merger or consolidation and its effect on policyholders and members of both corporations. The plan shall also contain the articles and bylaws of the proposed new corporation.

(2) COMMISSIONER'S APPROVAL REQUIRED. No proposed merger or consolidation plan under this section may be submitted to the members until the commissioner approves it.

(3) GROUNDS FOR DISAPPROVAL. The commissioner shall approve the plan unless he finds, after a hearing, that it is contrary to the law or to the interests of insureds or of the public of this state.

(4) MEMBERS' APPROVAL REQUIRED. The plan must be approved separately by two-thirds of the votes cast by the members of each corporation included in the plan.

(5) APPLICATION OF CH. 181. Except as otherwise provided in this section, ss. 181.42 and 181.48 apply to service insurance corporations.

NOTE: The limitation in the first sentence of sub. (1) is desirable to maintain a solidarity of interest among members.

Subs. (2) and (3) provide for approval or for disapproval of the transaction by the commissioner, similar to s. 611.72.

Sub. (4) requires a two-thirds vote for members' approval of a merger or consolidation plan.

613.74 Voluntary dissolution of solvent service insurance corporations. (1) GENERAL. Sections 181.50 to 181.555 apply to service insurance corporations, except as provided in subs. (2) to (4).

(2) PLAN OF DISSOLUTION. At least 60 days prior to the submission to members of any proposed voluntary dissolution of a service insurance corporation under s. 181.50 the plan shall be filed with the commissioner. The commissioner may require the submission of such additional information as will establish the financial condition of the corporation or other facts relevant to the proposed dissolution. If the members adopt the resolution to dissolve, the commissioner shall, within 30 days after the adoption of the resolution, begin to examine the corporation. He shall approve the

dissolution unless he finds, after a hearing, that it is insolvent or may become insolvent in the process of dissolution. Upon approval, the corporation may dissolve under ss. 181.51 to 181.555, except that the last sentence of s. 181.555 does not apply. Upon disapproval, the commissioner shall petition the court for liquidation or for rehabilitation under ch. 645.

(3) **CONVERSION TO INVOLUNTARY LIQUIDATION.** The corporation may at any time during the liquidation under ss. 181.51 to 181.555 apply to the commissioner to have the liquidation continued under his supervision; thereupon the commissioner shall apply to the court for liquidation under s. 645.41 (10).

(4) **REVOCAION OF VOLUNTARY DISSOLUTION.** If the corporation revokes the voluntary dissolution proceedings under s. 181.53 a copy of the revocation of voluntary dissolution proceedings shall be filed with the commissioner.

NOTE: This section closely parallels s. 611.74.

613.75 Conversion of a service insurance corporation into a stock or mutual insurance corporation. (1) **AUTHORIZATION.** Any service insurance corporation may be converted into an insurance corporation under ch. 611 upon complying with the applicable provisions of that chapter and of sub. (2).

(2) **APPROVAL BY PERSONS ENTITLED TO VOTE.** The commissioner shall not issue an organization permit under s. 611.13 (3) or a certificate of authority under s. 611.22 (3) unless the conversion has been approved by a mail vote of at least two-thirds of those voting, including an affirmative vote of at least half of the members, or by a vote of at least two-thirds of the members present or represented by proxy at a special meeting called for that purpose.

NOTE: Service insurance corporations as conceived in this chapter are cooperative enterprises run by and for the convenience and benefit of the providers of certain services. (This does not suggest that the corporation may not have wider public interests and motives, of course.) Their interests in marketing their services are different from the investment interests of stockholders in a stock corporation.

Thus, when a corporation organized under this chapter decides to convert into either a stock or mutual corporation, it involves a considerable change in the basic nature of the operation. While it is likely that the stock will be held initially only by existing members, i.e., by providers of services, the organization thereafter becomes open to investors having nothing but a financial interest. There is no reason why such a corporation should not then be treated exactly like any other stock insurance corporation. If the conversion is to a mutual insurer, the locus of control is changed from members to policyholders, who will at least theoretically control the converted corporation.

Providers of services now have the power to organize a stock insurance corporation for the purpose of marketing their services. There is no reason why they should not also be permitted to convert later.

613.78 Transfer of business or assets. (1) **GENERAL.** Section 181.49 applies to service insurance corporations except as modified by subs. (2) and (3).

(2) **REPORT TO COMMISSIONER.** Any action by which a service insurance corporation proposes to transfer to another person or to reinsure any part of its insurance business, other than in the normal and usual course of business, or to sell, lease, exchange, mortgage, pledge or otherwise dispose of or encumber more than 25% of its assets, shall be reported to the commissioner not less than 30 days in advance of the proposed effective date. The commissioner may defer the effective date for an

additional period not exceeding 30 days by written notice to the corporation before expiration of the initial 30-day period.

(3) **DISAPPROVAL.** The commissioner may, within the 30-day period or its extension under sub. (2), prohibit the proposed action if it is contrary to law, the interests of insureds or the public or if it will make possible the circumvention of any of the requirements of ss. 613.72 to 613.75.

NOTE: This follows closely s. 611.78.

SUBCHAPTER VI SUPPLEMENTARY PROVISIONS

613.80 Hospital service insurance corporations. (1) **STATEMENT OF PURPOSE.** This subsection is a guide to the interpretation and application of sub. (2). Payment for adequate health care services is a problem of great social importance, with many ramifications. New and better methods of payment for and delivery of health care services are needed. It is hereby stated to be the public policy of this state to encourage the formation of nonprofit hospital service insurance corporations under this chapter, on an economically sound basis, in the hope that they may ease the burden of payment for hospital services and health care for large numbers of the population, without any burden on the public treasury and free from the profit motive. If such corporations can contribute to the solution of such serious social and economic problems, they merit the support of the state. It is the policy of this state that such corporations should develop without changing the status of voluntary hospitals and that, by enabling many citizens to procure adequate hospital services for themselves, they should leave the hospitals more able to provide subsidized services to those unable to pay.

(2) **AUTHORIZATION.** Nonprofit hospital service insurance corporations may be organized under this chapter to establish, maintain and operate service plans to implement sub. (1).

(3) **CONTINUATION.** Any corporation existing under s. 182.032, 1973 stats., prior to the effective date of this act (1975) is deemed to have been organized under this section.

NOTE: This section puts a special charge on hospital service insurance corporations that is not put on other service corporations. It is a laudatory objective and it is to be hoped that it can be achieved. It is a modernized version of s. 182.032 (1).

613.81 Tax exemption for hospital service insurance corporations. Every nonprofit service insurance corporation organized under s. 613.80 which does not pay any dividends, benefits or pecuniary profits to any members or directors is, except for purposes of the franchise tax measured by net income, a charitable and benevolent corporation, and its property and the transfer of property to it by gift or inheritance, is exempt from taxation as provided in ss. 70.11, 72.15 and subch. IV of ch. 72.

NOTE: This retains the preferred tax treatment enjoyed by plans organized under s. 182.032 (5).

613.90 Vicarious liability. No member of or other provider for a service insurance corporation is liable, solely by virtue of his relationship with the corporation or of the providers' contract, for any act, omission or default of the corporation or of any other member of or provider for the corporation.

NOTE: This continues the thrust of s. 182.032 (7), but extends it to all service insurance corporations. This formulation would not preclude explicit assumption of such obligations by separate contract, not through a provider's contract. There is no reason such assumption should not be possible, though

it is difficult to imagine circumstances under which participants in the plan would wish to assume vicarious liability.

613.92 Administrative agent. Service insurance corporations organized pursuant to the authorization under ss. 148.03, 447.13 and 613.80 may act as administrative agent for a government instrumentality performing an insurance, public assistance or related function.

SECTION 23. Chapter 628 (title) of the statutes is created to read:

CHAPTER 628

INSURANCE MARKETING

NOTE: This section is not needed if the Insurance Marketing bill is enacted first.

SECTION 24. 628.22, 628.35, 628.36 and 628.37 of the statutes are created to read:

PREFATORY NOTE: This section is not needed if the Insurance Marketing bill is enacted first.

628.22 Licensing of agents representing service insurance corporations. Agents representing service insurance corporations are subject to s. 209.04.

NOTE: Though service insurance corporations sell mainly services rather than indemnity, their representatives need to be qualified in the same way as other insurance intermediaries. They should be as professionally qualified as agents for commercial insurers or as brokers. Agents of nonprofit service plans are now required to be licensed, under s. 209.04 (11), which subjects them to the remainder of s. 209.04. This section replaces s. 209.04 (11). The whole of s. 209.04 will be replaced by provisions in a new ch. 628. When it is enacted, this section can be repealed.

There is an exemption in s. 209.04 (11) which would need to be temporarily retained were it not that it is repeated in s. 209.047, defining agents.

628.35 Prohibition of exclusive contracts. No insurer may make, enforce or participate in any contract or other arrangement for exclusive services of a provider that prevents or materially inhibits any other insurer authorized to do business in this state from entering into a contract or other arrangement with any provider of services that the other insurer has contracted to supply or for which it has promised indemnity under its insurance contracts, unless:

- (1) The provider is an individual who is an employe of the insurer;
- (2) The provider is a corporation owned by the insurer;
- (3) The provider uses the insurer's name under a franchise arrangement; or
- (4) The case is within a class for which the commissioner by rule establishes an exception after a finding that the contract or other arrangement does not seriously impede the effective operation of a legitimate insurance business by other insurers.

NOTE: This parallels but is broader than the first sentence of s. 185.981 (3). It is inconsistent with s. 182.032 (6), which is repealed by this proposal. The provision prevents the creation of local monopolies of services that are the subject of insurance coverage.

628.36 Limitations on corporations supplying health care services. (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.

(2) **DISCRIMINATION AGAINST PROFESSIONALS.** No health care plan or contract may prevent any person covered under the plan from choosing freely among licensed health care professionals who have agreed to participate in the plan and abide by its terms, except by requiring the person covered to select primary providers to be used when reasonably possible. No licensed professional may be required to participate exclusively in the plan as a condition for participation in it, nor may any licensed professional be denied the opportunity to participate in the plan under its terms, except for professional cause.

(3) **EXEMPTION BY RULE.** By rule the commissioner may exempt from the application of any part of subs. (1) and (2) plans which provide innovative approaches to the delivery of health care and which cannot operate successfully consistent with subs. (1) and (2). The commissioner may promulgate such a rule only if he finds that the interests of the public require such innovations either as an experiment or to supply health care services that are not otherwise available in adequate quantity or quality. The rule shall be as narrow as is compatible with the success of the plans.

NOTE: Sub. (1) substantially parallels s. 185.982 (2), relative to payment methods for cooperative sickness plans. It applies more broadly to service plans, whether dominated by providers or by policyholders, i.e., whether under ch. 611 or ch. 613.

Sub. (2) continues the latter part of s. 185.982 (1).

Sub. (3) provides for the need to experiment with health care systems.

628.37 Preservation of professional relationships in professional services. No insurance plan related to or providing health care, legal or other professional services may alter the direct relationship and responsibility of professional persons to their patients or clients for the professional services rendered. All professional relationships are subject to the same rules of contract and tort law and professional ethics as if no insurance plan were involved.

NOTE: This is an adaptation of part of s. 182.032 (2) (f), and of corresponding provisions in the present enabling statutes for other health care plans. See ss. 148.03 (1), 447.13 (1), 449.15 (1) and 450.13 (1). It is here expanded beyond health care to include legal and any other professional services, for which insurance contracts are likely to be more common in the future. No one is to be deprived of his remedies for breach of contract or malpractice because the relationship was one created, perhaps without any effective power of selection by the patient or client, under the insurance plan. If there are problems with malpractice suits they should be solved directly, in such a way as not to deprive insured persons who do not make their own arrangements of equal rights with uninsured persons or with insured persons who do make their own arrangements. Moreover, it makes clear as a matter of insurance law that the professional relationship is also preserved.

SECTION 25. Chapter 632 (title) of the statutes is created to read:

CHAPTER 632

INSURANCE CONTRACTS IN SPECIFIC LINES

SECTION 26. 632.86, 632.87, 632.89 and 632.90 of the statutes are created to read:

632.86 Restrictions on choice of health care services or professionals. Subject to any power given by statute to the commissioner to disapprove the form, a contract providing a plan of health care services or payment therefor may limit its application

to such hospitals, other health care services or health care professionals as have agreed to participate in the plan and abide by its terms. No such contract may place on the person covered thereunder the obligation of choosing nor give the corporation the right to require the choice of any particular health care service or professional among those contracting with the corporation, except by requiring the selection of primary providers to be used when reasonably possible.

NOTE: This is essentially s. 182.032 (3) (c), and a small part of s. 182.032 (2) (f), 185.982 (1) (second and third sentences), and s. 148.03 (1) (last sentence), and corresponding provisions in the enabling acts of other health care services. See also comment on s. 628.37. It is made applicable to commercial insurers to implement the policy contained in ss. 204.31 (3) (a) 9. b., 204.321 (2) (c) and 204.33. Freedom of choice among the contracting hospitals has been thought desirable by the legislature in the past. The requirement of selection of primary providers may be essential for the operation of some of HMO's. It compels the participant to make his selection in advance of the need for the service, to facilitate arranging the logistics of the plan.

632.87 Restrictions on health care services. No insurer may refuse to provide or pay for benefits for health care services provided by a licensed health care professional on the ground that they were not rendered by a physician as defined in s. 990.01 (28), unless the contract clearly excludes services by such practitioners.

NOTE: This continues (and expands the scope of) s. 207.04 (1) (k), which does not deal with an unfair marketing practice but an unduly restrictive interpretation of an insurance contract. Presently it applies only to podiatrists but the same principles apply to all health care professionals. Since the legislature has licensed podiatrists (s. 448.10 et. seq.), as well as other health care professionals who are not physicians, applicable insurance contracts should provide benefits for their services or payment to them as well as for those of physicians, unless they are specifically and clearly excluded by a policy which has been approved by the commissioner. But general principles of freedom of contract should be operative if the contract is clear enough. Parties negotiating for insurance coverage should be free to decide what kind of health care services they want and are willing to pay for.

632.89 Required coverage of alcoholism and other diseases. (1) DEFINITIONS. In this section:

(a) "Outpatient treatment facility" means a facility licensed or approved by the department whose outpatient services meet the standards established in s. 51.42 (12) and provides at a minimum those 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.

(b) "Hospital" is a facility described in s. 140.24 (1) (a) and (c) which is licensed under s. 140.26 or is an approved public or private treatment facility for the treatment of alcoholics as defined in s. 51.45 (2) (b) and (c).

(c) "Physician" has the meaning designated in s. 990.01 (28).

(d) "Outpatient treatment" means services, medications, equipment and supplies performed or furnished by or under the supervision of or referral from a physician at a hospital or outpatient treatment facility to a patient who is not a bed patient of the hospital or outpatient treatment facility.

(2) REQUIRED COVERAGE FOR ALL INSURERS UNDER CHAPTERS 611 AND 613. (a) *Scope.* Each group disability policy or contract providing hospital treatment coverage shall include coverage for:

1. Inpatient hospital treatment of mental and nervous disorders, alcoholism and drug abuse.

2. Hospital treatment for kidney disease, as defined by the department of health and social services under sub. (6). Kidney disease coverage shall include dialysis treatment approved by the department under s. 49.48 (2) (a), in an amount not less than \$30,000 annually.

(b) *Exclusions in coverage.* Except as provided in par. (c), coverages under par. (a) may not be subject to exclusions or limitations which are not generally applicable to other conditions covered under the policy or contract.

(c) *Minimum confinement.* Coverages under par. (a) 1 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 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 \$500 in any 12-month period. The department of health and social services may by rule promulgated under ch. 227 adjust this amount at 2-year intervals to reflect changes in the cost of medical care.

(3) **ADDITIONAL REQUIRED COVERAGE FOR ORGANIZATIONS SUBJECT TO CH. 613.** Any corporation or other organization subject to ch. 613 is subject to sub. (2) and in addition its group disability policies or contracts shall provide:

(a) Outpatient hospital treatment of alcoholism;

(b) Outpatient and home dialysis treatment for kidney disease and kidney transplantation expenses; and

(c) Protection for both recipient and donor of any transplant organs, as provided in s. 49.48 (3) (b).

(4) **AMOUNT OF PROTECTION FOR ORGANIZATIONS SUBJECT TO SUB. (3).** Coverage under sub. (3) (b) and (c), combined with coverage under sub. (2) (a) 2, shall not be less than \$30,000 annually.

(5) **MEDICARE EXCLUSION.** No insurer or other organization subject to this section is required to duplicate coverage available under the federal medicare program.

(6) **RULES.** 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 section, which shall not be inconsistent with or less stringent than applicable federal standards.

632.90 Tuberculosis coverage. No policy of disability insurance, whether under subch. II of ch. 40 or otherwise, may include hospital or medical expense coverage unless it contains a provision for a minimum 90 days' continuous coverage of costs for tuberculosis charges, fees or maintenance under ch. 50, including both inpatient care and outpatient dispensary charges or fees. This section applies to all such policies issued, delivered or renewed after August 5, 1973.

NOTE: This section continues former s. 204.323.

SECTION 27. 645.02 (5) of the statutes is amended to read:

645.02 (5) All ~~nonprofit service plans as defined in s. 200.26 (1)~~ service insurance corporations under ch. 613 and all fraternal benefit and mutual benefit societies as defined in s. 208.01 (1).

SECTION 28. **Cross reference changes.** In the sections listed below in column A, the cross references in column B are changed to the cross references in column C:

A Statute Sections	B Old Cross References	C New Cross References
40.10 (2)(b)	ch. 148 or s. 182.032	ch. 613
40.14 (1)	s. 148.03 or 182.032	ch. 613
49.45 (2) (b) 2	s. 148.03, 182.032 or 447.13	s. 148.03, 447.13 and ch. 613
185.981 (3)	182.032	148.03 and 613.80
204.31 (3) (am) 1	200.26 (6) (a)	632.89 (6)

SECTION 29. Program responsibility citations. (1) In the list of program responsibility citations enumerated for the office of the commissioner of insurance under section 15.731 of the statutes, reference to sections “148.03”, “182.032”, “447.13” and “450.13” are deleted.

(2) In the list of program responsibility citations enumerated for the department of health and social services under section 15.191 (intro.) of the statutes, reference to section “632.89 (2) (d) and (6)” is inserted.
