

CHAPTER 619

RISK-SHARING PLANS

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SUBCHAPTER I

GENERAL PROVISIONS

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

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

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

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

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

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

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

2. Each health care liability insurance plan shall require participation by all insurers insuring persons in this state against liability resulting from personal injuries. Any deficit in a health care liability insurance plan in any year shall be recouped by actuarially sound rate increases which take into account any plan surplus and are applicable prospectively.

Each plan shall maintain a surplus determined by the commissioner acting under ss. 623.11 and 623.12.

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

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

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

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

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

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

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

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

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

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

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91-92 Wis. Stats. 4190

(7) **HEALTH CARE LIABILITY POLICY LIMITS.** (a) *Primary coverage plans.* Health care liability insurance plans established under this paragraph shall provide minimum coverage to insureds in the amount of not less than \$200,000 for each occurrence and \$600,000 for all occurrences in any one policy year for occurrences before July 1, 1987, \$300,000 for each occurrence and \$900,000 for all occurrences in any one policy year for occurrences on or after July 1, 1987 and before July 1, 1988, and \$400,000 for each occurrence and \$1,000,000 for all occurrences in any one policy year for occurrences on or after July 1, 1988, for the protection of persons who are legally entitled to recover damages from the insured for errors, omissions or neglect in the performance of the insured's professional services. If an insured has excess limits liability coverage or such coverage is available to the insured, the coverage provided under such plans shall be equal to the minimum level of such excess limits coverage. If the insured does not have excess limits liability coverage and such coverage is not available to the insured, the commissioner may establish minimum levels of coverage higher than the minimum limits specified in this paragraph for such plans.

(b) *Supplemental liability coverage plans.* Health care liability insurance plans of the kind authorized under par. (a) may be established by the commissioner under this paragraph to provide coverage to supplement primary coverage provided by insurers authorized under ch. 611 or 618. Such plans may be in an amount no greater than \$100,000 for each occurrence and \$300,000 for all occurrences in any one policy year, but the total combined primary and supplemental coverage may not exceed the limits established by s. 655.23 (4).

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

(8m) **PREMIUM ASSESSMENT.** Health care liability plans established under this chapter shall pay a fee equal to 2% of net premiums collected to the department of administration for services from state agencies not otherwise charged to the plan.

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

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

History: 1975 c. 2, 79; 1975 c. 147 s. 54; 1975 c. 199; 1977 c. 131, 172; 1979 c. 56, 57; 1979 c. 102 s. 236 (6); 1979 c. 177; 1983 a. 27, 158, 192; 1985 a. 135, 176, 335, 340; 1989 a. 56 s. 259; 1989 a. 187 s. 29; 1991 a. 315

Questions regarding plans and boards discussed 71 Atty Gen 127.

619.02 State contribution for federally reinsured losses.

(1) **ASSESSMENT OF INSURERS.** The commissioner is authorized to assess each insurance company authorized to do business in this state an aggregate amount sufficient to provide a fund

to reimburse the U.S. secretary of housing and urban development in the manner set forth in sec. 1223 (a) (1) of the national housing act as amended by sec. 1103 of the urban property protection and reinsurance act of 1968, P.L. 90-448, 82 Stat. 476. The assessment shall be on those lines reinsured during the current year in this state by the U.S. secretary of housing and urban development pursuant to such act. The assessment shall be in the proportion that the premiums earned during the preceding calendar year by each such company in this state bear to the aggregate premiums earned on those lines in this state by all insurers. The fund may be provided in whole or in part from appropriations by the legislature.

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

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

History: 1979 c. 102; 1991 a. 315.

619.04 Mandatory health care liability risk-sharing plans.

(1) The commissioner shall promulgate rules establishing a plan of health care liability coverage for health care providers as defined in s. 655.001 (8).

(3) The plan shall operate subject to the supervision and approval of a board of governors consisting of 3 representatives of the insurance industry appointed by and to serve at the pleasure of the commissioner, a person to be named by the state bar association, a person to be named by the Wisconsin academy of trial lawyers, 2 persons to be named by the Wisconsin medical society, a person to be named by the Wisconsin hospital association, the commissioner or a designated representative employed by the office of the commissioner and 4 public members at least 2 of whom are not attorneys or physicians and are not professionally affiliated with any hospital or insurance company, appointed by the governor for staggered 3-year terms. The commissioner or the commissioner's representative shall be the chairperson of the board of governors. Board members shall be compensated at the rate of \$50 per diem plus actual and necessary travel expenses.

(5) The plan shall offer professional health care liability coverage in a standard policy form. The plan shall include, but not be limited to, the following:

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

(b) A rating plan which takes into consideration the loss and expense experience of the individual health care provider which resulted in the payment of money, by the plan or other sources, for damages arising out of the rendering of health care by the health care provider or an employe of the health care provider, except that an adjustment to a health care provider's premiums may not be made under this paragraph prior to the receipt of the recommendation of the patients compensation fund peer review council under s. 655.275 (5) (a) and the expiration of the time period provided, under s. 655.275 (7), for the health care provider to comment or prior to the expiration of the time period under s. 655.275 (5) (a).

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

(5m) (a) Every rule under sub. (5) (b) shall provide for an automatic increase in a health care provider's premiums, except as provided in par. (b), if the loss and expense experience of the plan and other sources with respect to the health care provider or an employe of the health care provider exceeds either a number of claims paid threshold or a dollar volume of claims paid threshold, both as established in the rule. The rule shall specify applicable amounts of increase corresponding to the number of claims paid and the dollar volume of awards in excess of the respective thresholds.

(b) The rule shall provide that the automatic increase does not apply if the board determines that the performance of the patients compensation fund peer review council in making recommendations under s. 655.275 (5) (a) adequately addresses the consideration set forth in sub. (5) (b).

(6) (a) If the plan accumulates funds in excess of the surplus required under s. 619.01 (1) (c) 2 and incurred liabilities, including reserves for claims incurred but not yet reported, the board of governors shall return those excess funds to the insureds by means of refunds or prospective rate decreases.

(b) The board of governors shall annually determine whether excess funds have accumulated.

(c) If it determines that excess funds have accumulated, the board of governors shall specify the method and formula for distributing the excess funds.

(9) Neither the state nor the board of governors shall be liable for any obligation of the plan or of the patients compensation fund under s. 655.27. The board of governors and members of any committee or subcommittee thereof shall be immune from civil liability for acts or omissions while performing their duties under this section and s. 655.27.

(10) If the commissioner makes a finding under s. 619.01 (1) (a) with respect to health care providers other than those described in sub. (1), the commissioner may, with the approval of the board established under sub. (3), promulgate rules permitting those health care providers to obtain coverage under s. 619.01 from the plan established under this section.

(11) Upon dissolution of the plan under this section, any assets in excess of incurred liabilities shall be paid to the general fund.

History: 1975 c. 37, 79, 199; 1977 c. 131; 1977 c. 203 s. 106; 1983 a. 158; 1983 a. 189 s. 329 (5); 1985 a. 340; 1987 a. 27; 1989 a. 187; 1991 a. 214, 315

SUBCHAPTER II

MANDATORY HEALTH INSURANCE RISK-SHARING PLAN

619.10 Definitions. In this subchapter:

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

(1m) "Alternative plan" means a health maintenance organization, as defined in s. 609.01 (2), or a preferred provider plan, as defined in s. 609.01 (4).

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

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

(3m) "Health care coverage revenue" means any of the following:

(a) Premiums received for health care coverage.

(b) Subscriber contract charges received for health care coverage.

(c) Health maintenance organization, limited service health organization or preferred provider plan charges received for health care coverage.

(d) The sum of benefits paid and administrative costs incurred for health care coverage under a medical reimbursement plan.

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

(4m) "HIV" means any strain of human immunodeficiency virus, which causes acquired immunodeficiency syndrome.

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

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

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

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

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

History: 1979 c. 313; 1985 a. 29; 1987 a. 70; 1989 a. 201, 332; 1991 a. 39, 269

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

History: 1979 c. 313.

Employe retirement income security act preempts any state law that relates to employe benefit plans. *General Split Corp. v. Mitchell*, 523 F. Supp. 427 (1981)

619.12 Eligibility determination. (1) Except as provided in subs. (1m) and (2), the board or administering carrier shall

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certify as eligible a person who is covered by medicare because he or she is disabled under 42 USC 423, a person who submits evidence that he or she has tested positive for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV, and any person who receives and submits any of the following based wholly or partially on medical underwriting considerations within 9 months prior to making application for coverage by the plan:

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

(am) A notice of cancellation of coverage from one or more insurers.

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

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

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

(1m) The board or administering carrier may not certify a person as eligible under circumstances requiring notice under sub. (1) (a) to (d) if the required notices were issued by one of the following:

(a) An insurance intermediary who is not acting as an administrator, as defined in s. 633.01.

(b) The administering carrier, unless the notice was issued to a person who had applied for insurance coverage from the administering carrier.

(2) (b) 1. Except as provided in subd. 2, no person who is covered under the plan and voluntarily terminates the coverage under the plan, is again eligible for coverage unless 12 months have elapsed since the person's latest voluntary termination of coverage under the plan.

2. Subdivision 1 does not apply to any person who terminates coverage under the plan because he or she is receiving, or is eligible to receive, medical assistance benefits.

(c) No person on whose behalf the plan has paid out \$500,000 or more is eligible for coverage under the plan.

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

(e) 1. Except as provided in subd. 2, no person who is eligible for health care benefits provided by an employer on a self-insured basis or through health insurance is eligible for coverage under the plan.

NOTE: Subd. 1 is shown as renumbered from par. (e) and amended eff. 3-1-93 by 1991 Wis. Act 250. Prior to 3-1-93 par. (e) reads:

1. No person who is eligible for health care benefits provided by an employer on a self-insured basis or through health insurance is eligible for coverage under the plan.

2. Subdivision 1 does not apply to a person who is eligible for health care benefits under the small employer health insurance plan under subch. II of ch. 635 if all of the following apply:

a. The person is certified in writing by a physician licensed under ch. 448 to have a severe and chronic or long-lasting physical or mental illness or disability.

b. The board determines that the coverage under the small employer health insurance plan under subch. II of ch. 635 is not substantially equivalent to or greater than the coverage under the plan.

c. The board finds that the person is eligible for coverage under the plan after a review process, determined by the

commissioner by rule under s. 619.123, that evaluates and approves the certification by the physician that the person has a severe and chronic or long-lasting physical or mental illness or disability.

NOTE: Subd. 2 is created eff. 3-1-93 by 1991 Wis. Act 250.

3. The requirements under sub. (1) (a) to (d) do not apply to a person who is found eligible for coverage under the plan by the board under subd. 2.

NOTE: Subd. 3 is created eff. 3-1-93 by 1991 Wis. Act 250.

(3) (a) Except as provided in pars. (b) and (c), no person is eligible for coverage under the plan for whom a premium, deductible or coinsurance amount is paid or reimbursed by a federal, state, county or municipal government or agency as of the first day of any term for which a premium amount is paid or reimbursed and as of the day after the last day of any term during which a deductible or coinsurance amount is paid or reimbursed.

(b) Persons for whom deductible or coinsurance amounts are paid or reimbursed under ch. 47 for vocational rehabilitation, under s. 49.48 for renal disease, under s. 49.485 (8) for hemophilia, under s. 49.483 for cystic fibrosis, or under s. 146.18 for special education, are not ineligible for coverage under the plan by reason of such payments or reimbursements.

(c) The commissioner, in consultation with the board, may promulgate rules specifying other deductible or coinsurance amounts that, if paid or reimbursed for persons, will not make the persons ineligible for coverage under the plan.

History: 1979 c. 313; 1983 a. 27, 215; 1985 a. 29, 73; 1987 a. 27, 70, 239; 1989 a. 201 s. 36; 1989 a. 332, 359; 1991 a. 39, 250

619.123 Rules for review of physician certification. The commissioner shall promulgate rules that establish the procedure to be used by the board under s. 619.12 (2) (e) 2. c. The rules shall provide for an insurer that would be affected by the decision of the board to participate in the review process to contest or support the physician's certification.

History: 1991 a. 250.

619.125 Health insurance risk-sharing plan fund. There is created a health insurance risk-sharing plan fund, under the management of the board, to fund administrative expenses.

History: 1981 c. 20; 1983 a. 27; 1991 a. 315.

619.13 Participation of insurers. (1) (a) Every insurer shall participate in the cost of administering the plan, except the commissioner may by rule exempt as a class those insurers whose share as determined under par. (b) would be so minimal as to not exceed the estimated cost of levying the assessment.

(b) Except as provided by a rule promulgated under s. 619.145 (4), every participating insurer shall share in the operating, administrative and subsidy expenses of the plan in proportion to the ratio of the insurer's total health care coverage revenue for residents of this state during the preceding calendar year to the aggregate health care coverage revenue of all participating insurers for residents of this state during the preceding calendar year, as determined by the commissioner.

(c) If assessments and other receipts by the commissioner, board or administering carrier exceed payments made to alternative plans in accordance with contracts entered into under s. 619.145 (3) and the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board to offset future losses or to reduce plan premiums. In this paragraph, "future losses" includes reserves for incurred but not reported claims.

(d) 1. Each insurer's proportion of participation under par. (b) shall be determined annually by the commissioner based

on annual statements and other reports filed by the insurer with the commissioner.

2. If the commissioner finds that the commissioner's authority to require insurers to report under chs. 600 to 646 and 655 is not adequate to permit the commissioner or the board to carry out the commissioner's or the board's responsibilities under this subchapter, the commissioner may promulgate rules requiring insurers to report the information necessary for the commissioner and the board to make the determinations required under this subchapter.

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

History: 1979 c. 313; 1981 c. 83; 1981 c. 314 s. 146; 1985 a. 29; 1989 a. 187 s. 29; 1991 a. 39, 269

619.135 Insurer assessments for premium and deductible reductions. (1) (a) Whenever a person becomes eligible for and obtains coverage under the plan as a result of receiving a notice under s. 619.12 (1) (am), (b) or (c), the commissioner shall levy an assessment of \$1,750 against the insurer that issued the notice, except that the commissioner may not levy an assessment if the notice of cancellation under s. 619.12 (1) (am) was issued on one of the permissible grounds under s. 631.36 (2) (a).

(b) An insurer shall pay an assessment levied under par. (a) within 30 days after receiving a notice of assessment.

(c) If an assessment levied under par. (a) is not paid within the time prescribed, the commissioner shall impose a penalty against the insurer in an amount established by the commissioner by rule.

(d) All assessments and penalties collected under this subsection shall be credited to the appropriation under s. 20.145 (7) (g).

(2) If the moneys under s. 20.145 (7) (a) and (g) are insufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a), or the commissioner determines that the moneys under s. 20.145 (7) (a) and (g) will be insufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a), the commissioner shall, by rule, increase the amount of the assessment under sub. (1) (a) or levy an assessment against every insurer, or a combination of both, sufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a).

(3) In addition to the assessments under subs. (1) (a) and (2), the commissioner may, by rule, establish an assessment to be levied against each insurer that issues a notice of rejection under s. 619.12 (1) (a) to a person who becomes eligible for and obtains coverage under the plan as a result of receiving the notice. Any assessments levied and collected under this subsection shall be credited to the appropriation under s. 20.145 (7) (g).

History: 1991 a. 39

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

(b) If an individual terminates medical assistance coverage and applies for coverage under the plan within 45 days after the termination and is subsequently found to be eligible under s. 619.12, the effective date of coverage for the eligible person

under the plan shall be the date of termination of medical assistance coverage.

(2) **MAJOR MEDICAL EXPENSE COVERAGE.** (a) The plan shall provide every eligible person who is not eligible for medicare with major medical expense coverage. Major medical expense coverage offered under the plan shall pay an eligible person's covered expenses, subject to sub. (3) and deductible and coinsurance payments authorized under sub. (5), up to a lifetime limit of \$500,000 per covered individual. The maximum limit under this paragraph shall not be altered by the board, and no actuarially equivalent benefit may be substituted by the board.

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

(3) **COVERED EXPENSES.** Except as restricted by cost containment provisions under s. 619.17 (4) and except as reduced by the board under s. 619.15 (3) (e), covered expenses shall be the usual and customary charges for the services provided by persons licensed under ch. 446. Except as restricted by cost containment provisions under s. 619.17 (4) and except as reduced by the board under s. 619.15 (3) (e), covered expenses shall also be the usual and customary charges for the following services and articles when prescribed by a physician licensed under ch. 448 or in another state:

(a) Hospital services.

(b) Basic medical-surgical services, including both in-hospital and out-of-hospital medical and surgical services, diagnostic services, anesthesia services and consultation services, subject to the limitations in this subsection.

(c) 1. Inpatient treatment in a hospital as defined in s. 632.89 (1) (c) or in a medical facility in another state approved by the board, for up to 30 days' confinement per calendar year due to alcoholism or drug abuse and up to 60 days' confinement per calendar year for nervous and mental disorders.

2. Outpatient services as defined in s. 632.89 (1) (e) for alcoholism, drug abuse or nervous and mental disorders, as follows:

a. The first \$500 of covered expenses per calendar year; and

b. An additional \$2,500 of covered expenses per calendar year, after satisfaction of the deductible and coinsurance requirements under sub. (5).

3. Subject to the limits under subd. 2 and to rules promulgated by the commissioner, services for the chronically mentally ill in community support programs operated under s. 51.421.

(d) Drugs requiring a physician's prescription.

(e) Services of a licensed skilled nursing facility for eligible persons eligible for medicare, to the extent required by s. 632.895 (3) and for not more than an aggregate 120 days during a calendar year, if the services are of the type which would qualify as reimbursable services under medicare. Coverage under this paragraph which is not required by s. 632.895 (3) is subject to the deductible and coinsurance requirements under sub. (5).

(f) Use of radium or other radioactive materials.

(g) Oxygen.

(h) Anesthetics.

(i) Prostheses other than dental.

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

(k) Diagnostic X-rays and laboratory tests.

(l) Oral surgery for partially or completely unerupted, impacted teeth and oral surgery with respect to tissues of the

mouth when not performed in connection with the extraction or repair of teeth.

(n) Services of a physical therapist.

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

(p) For persons not eligible for medicare, services of a licensed skilled nursing facility, only to the extent required by s. 632.895 (3).

(q) Any other health insurance coverage, only to the extent required under subch. VI of ch. 632.

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

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

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

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

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

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

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

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

(g) Dental care except as provided in sub. (3) (m).

(h) Eyeglasses and hearing aids.

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

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

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

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

(m) Experimental treatment, as determined by the board or its designee.

(5) PREMIUMS, DEDUCTIBLES AND COINSURANCE. (a) The plan shall offer a deductible in combination with appropriate premiums determined under this subchapter for major medical expense coverage required under this section. For coverage offered to those persons eligible for medicare, the plan shall offer a deductible equal to the deductible charged by part A of title XVIII of the federal social security act, as amended. The deductible amounts for all other eligible persons shall be dependent upon household income as determined under s. 619.165. For eligible persons under s. 619.165 (1) (b) 1, the deductible shall be \$500. For eligible persons under s. 619.165 (1) (b) 2, the deductible shall be \$600. For eligible persons under s. 619.165 (1) (b) 3, the deductible shall be \$700. For eligible persons under s. 619.165 (1) (b) 4, the

deductible shall be \$800. For all other eligible persons who are not eligible for medicare, the deductible shall be \$1,000. With respect to all eligible persons, expenses used to satisfy the deductible during the last 90 days of a calendar year shall also be applied to satisfy the deductible for the following calendar year. The schedule of premiums shall be promulgated by rule by the commissioner. The commissioner shall set rates at 60% of the operating and administrative costs of the plan.

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

(c) If the aggregate of the covered costs not paid by the plan under par. (b) and the deductible exceeds \$500 for an eligible person receiving medicare, \$2,000 for any other eligible person during a calendar year or \$4,000 for all eligible persons in a family, the plan shall pay 100% of all covered costs incurred by the eligible person during the calendar year after the payment ceilings under this paragraph are exceeded.

(d) Notwithstanding pars. (a) to (c), the board may establish different deductible amounts, a different coinsurance percentage and different covered costs and deductible aggregate amounts from those specified in pars. (a) to (c) in accordance with cost containment provisions established by the commissioner under s. 619.17 (4) (a) and for individuals who enroll in an alternative plan under s. 619.145.

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

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

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

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

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269

619.145 Alternative plans. (1) The board may offer to persons eligible for coverage under s. 619.12 the opportunity to enroll, on a voluntary basis, in an alternative plan that uses managed care and that the commissioner determines provides benefits that are substantially equivalent to or greater than the benefits provided under the plan. A person who enrolls in an alternative plan under this section is ineligible for coverage under the plan for 12 months after enrolling in the alternative plan.

(2) An alternative plan that provides coverage under this section to persons eligible for coverage under s. 619.12 may

limit the number of such persons who may enroll in the alternative plan. Any such enrollment limitation may not be based on medical underwriting considerations.

(3) An alternative plan that provides coverage under this section to persons eligible for coverage under s. 619.12 shall contract with the board to provide such coverage. The contract shall specify all of the following:

(a) Notwithstanding s. 619.14, the benefits provided under the alternative plan.

(b) Requirements for managed care and marketing practices.

(c) Grievance procedures for persons with coverage under the alternative plan.

(d) The payment of fees or premiums to the alternative plan for the coverage provided to persons eligible under s. 619.12.

(e) Subject to sub. (4), a reduction in the alternative plan's assessment under s. 619.13 for operating and administrative, but not subsidy, expenses of the plan.

(f) Any other terms that the board considers necessary.

(4) A contract under sub. (3) may not provide for a reduction in the assessment under s. 619.13 against an alternative plan unless the assessment reduction has been adopted by rule under s. 619.15 (4) (e).

History: 1991 a 269.

619.15 Board of governors. (1) The plan shall operate subject to the supervision and approval of a board consisting of representatives of 2 participating insurers which are non-profit corporations, 2 other participating insurers, and 3 public members, appointed by the commissioner for staggered 3-year terms. In addition, the commissioner or a designated representative from the office of the commissioner shall be a member of the board. The public members shall not be professionally affiliated with the practice of medicine, a hospital or an insurer. At least 2 of the public members shall be individuals reasonably expected to qualify for coverage under the plan or the parent or spouse of such an individual. The commissioner or the commissioner's representative shall be the chairperson of the board. Board members, except the commissioner or the commissioner's representative, shall be compensated at the rate of \$50 per diem plus actual and necessary expenses.

(2) Annually, the board shall make a report to the members of the plan and to the chief clerk of each house of the legislature, for distribution to the appropriate standing committees under s. 13.172 (3), summarizing the activities of the plan in the preceding calendar year. The annual report shall define the cost burden imposed by the plan on all policyholders in this state.

(3) The board shall:

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

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

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

(d) Develop and implement a program to publicize the existence of the plan, the eligibility requirements and proce-

dures for enrollment, and to maintain public awareness of the plan.

(e) Establish for payment of covered expenses, a payment rate that is 10% less than the charges approved by the administering carrier for reimbursement of covered expenses under s. 619.14 (3). A provider of a covered service or article may not bill an eligible person who receives the service or article for any amount by which the charge is reduced under this paragraph.

(4) The board may:

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

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

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

(d) Contract with alternative plans under s. 619.145 (3).

(e) By rule provide for a reduction in the assessment under s. 619.13 against an alternative plan that provides coverage to eligible persons.

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

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

(7) (a) The board is not liable for any obligation of the plan.

(b) Members of the board are state officers for purposes of s. 895.46.

History: 1979 c 313; 1981 c 83; 1987 a 186, 399; 1991 a 269.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(em) The administering carrier shall make any payments required by a contract entered into under s. 619.145 (3).

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

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

History: 1979 c. 313; 1985 a. 29; 1991 a. 269.

619.165 Reductions in premiums for low-income eligible persons. (1) (a) The board shall reduce the premiums established by the commissioner under s. 619.11 in conformity with ss. 619.14 (5) and 619.17, for the eligible persons and in the manner set forth in pars. (b) to (d).

(b) If the household income, as defined in s. 71.52 (5) and as determined under par. (d), of an eligible person is equal to or greater than the first amount and less than the 2nd amount listed in any of the following, the board shall reduce the premium for the eligible person, as established by the commissioner, to the rate shown after the amounts:

1. If equal to or greater than \$0 and less than \$10,000, to 100% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under the plan.

2. If equal to or greater than \$10,000 and less than \$14,000, to 106.5% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under the plan.

3. If equal to or greater than \$14,000 and less than \$17,000, to 115.5% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under the plan.

4. If equal to or greater than \$17,000 and less than \$20,000, to 124.5% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under the plan.

(d) The board shall establish and implement the method for determining the household income of an eligible person under par. (b).

(2) The board shall direct the administering carrier to collect, under s. 619.16 (3) (b), from the eligible persons under sub. (1) the premiums as reduced under sub. (1) rather than the premiums established by the commissioner.

(3) The commissioner shall forward to the board moneys received under s. 20.145 (7) (a) and (g) in an amount sufficient to reimburse the plan for premium reductions under sub. (1) and deductible reductions under s. 619.14 (5) (a).

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39.

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

(1) Subject to s. 619.14 (5) (a), a rating plan calculated in accordance with generally accepted actuarial principles.

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

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

(4) (a) Cost containment provisions established by the commissioner by rule.

History: 1979 c. 313; 1983 a. 27; 1987 a. 27; 1991 a. 39.

619.175 Waiver or exemption from provisions prohibited. Except as provided in s. 619.13 (1) (a), the commissioner may not waive, or authorize the board to waive, any of the requirements of this subchapter or exempt, or authorize the board to exempt, an individual or a class of individuals from any of the requirements of this subchapter.

History: 1991 a. 39.

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

History: 1979 c. 313; 1981 c. 314.