CHAPTER 609

DEFINED NETWORK PLANS

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Cross-reference: See definitions in ss. 600.03 and 628.02.
Cross-reference: See also ch. Ins 9, Wis. adm. code.

609.001 Joint ventures; legislative findings. (1) The legislature finds that increased development of health maintenance organizations, preferred provider plans and limited service health organizations may have the effect of putting small, independent health care providers at a competitive disadvantage with larger health care providers. In order to avoid monopolistic situations and to provide competitive alternatives, it may be necessary for those small, independent health care providers to form joint ventures. The legislature finds that these joint ventures are a desirable means of health care cost containment to the extent that they increase the number of entities with which a health maintenance organization, preferred provider plan or limited service health organization may choose to contract and to the extent that the joint ventures do not violate state or federal antitrust laws.

(2) The legislature finds that competition in the health care market will be enhanced by allowing employers and organizations which otherwise act independently to join together in a manner consistent with the state and federal antitrust laws for the purpose of purchasing health care coverage for employees and members. These joint ventures will allow purchasers of health care coverage to obtain volume discounts when they negotiate with insurers and health care providers. These joint ventures should result in an improved business climate in this state because of reduced costs for health care coverage.

History: 1985 a. 29.

609.01 Definitions. In this chapter:

(1b) "Defined network plan" means a health benefit plan that requires an enrollee of the health benefit plan, or creates incentives, including financial incentives, for an enrollee of the health benefit plan, to use providers that are managed, owned, under contract with, or employed by the insurer offering the health benefit plan.

(1c) "Emergency medical condition" has the meaning given in s. 632.85 (1) (a).

(1d) "Enrollee" means, with respect to a defined network plan, preferred provider plan, or limited service health organization, a person who is entitled to receive health care services under the plan.

(1g) (a) Except as provided in par. (b), "health benefit plan" means any hospital or medical policy or certificate.

(b) "Health benefit plan" does not include any of the following:

1. Coverage that is only accident or disability income insurance, or any combination of the 2 types.

2. Coverage issued as a supplement to liability insurance.

3. Liability insurance, including general liability insurance and automobile liability insurance.

4. Worker's compensation or similar insurance.

5. Automobile medical payment insurance.

6. Credit-only insurance.

7. Coverage for on-site medical clinics.

8. Other similar insurance coverage, as specified in regulations issued by the federal department of health and human services, under which benefits for medical care are secondary or incidental to other insurance benefits.

9. If provided under a separate policy, certificate or contract of insurance, or if otherwise not an integral part of the policy, certificate or contract of insurance: limited-scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those benefits; and such other similar, limited benefits as are specified in regulations issued by the federal department of health and human services under section 2791 of P.L. 104-191.

10. Hospital indemnity or other fixed indemnity insurance or

coverage only for a specified disease or illness, if all of the following apply:

a. The benefits are provided under a separate policy, certificate or contract of insurance.

b. There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

c. Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

11. Other insurance exempted by rule of the commissioner.

(1j) "Health care costs" means consideration for the provision of health care, including consideration for services, equipment, supplies and drugs.

(1m) "Health care plan" has the meaning given under s. 628.36 (2) (a) 1.

(2) "Health maintenance organization" means a health care plan offered by an organization established under ch. 185 or 193, 611, 613 or 614 or issued a certificate of authority under ch. 618 that makes available to its enrollees, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers participating in the plan.

(3) "Limited service health organization" means a health care plan offered by an organization established under ch. 185, 611, 613 or 614 or issued a certificate of authority under ch. 618 that makes available to its enrollees, in consideration for predetermined periodic fixed payments, a limited range of health care services performed by providers participating in the plan.

(3m) "Participating" means, with respect to a physician or other provider, under contract with a defined network plan, preferred provider plan, or limited service health organization to provide health care services, items or supplies to enrollees of the defined network plan, preferred provider plan, or limited service health organization.

(3r) "Physician" has the meaning given in s. 448.01 (5).

(4) "Preferred provider plan" means a health care plan offered by an organization established under ch. 185, 193, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrollees, without referral and for consideration other than predetermined periodic fixed payments, coverage of either comprehensive health care services or a limited range of health care services, regardless of whether the health care services are performed by participating or nonparticipating providers.

(4m) "Primary care physician" means a physician specializing in family medical practice, general internal medicine or pediatrics.

(5) "Primary provider" means a participating primary care physician, or other participating provider authorized by the defined network plan, preferred provider plan, or limited service health organization to serve as a primary provider, who coordinates and may provide ongoing care to an enrollee.

(5m) "Provider" means a health care professional, a health care facility or a health care service or organization.

(7) "Standard plan" means a health care plan other than a health maintenance organization or a preferred provider plan.

History: 1985 a. 29; 1989 a. 23; 1997 a. 237; 2001 a. 16; 2005 a. 441 ss. 107, 108; 2007 a. 96.

Under this section, an HMO enrollee has no personal liability for the costs of covered health care received. A hospital only has recourse against the HMO and may not assert its lien rights under this section against insurance proceeds paid by a tortfeasor's insurer to the HMO enrollee. Dorr v. Sacred Heart Hospital, 228 Wis. 2d 425, 597 N.W.2d 462 (Ct. App. 1999), 98-1772.

Sections 609.01 and 609.91 do not prohibit HMOs from asserting contractual subrogation rights with respect to actual medical expenses incurred by an HMO for medical care covered by the HMO's contract with an enrollee. Sub. (2) says that an HMO is an entity that makes available to its enrollees, in consideration for predetermined periodic fixed payments, comprehensive health care services but does not put in place a general limitation on all sources of funds available to HMOs. Torres v. Dean Health Plan, Inc. 2005 WI App 89, 282 Wis. 2d 725, 698 N.W.2d 107, 03-3274.

609.03 Indication of operations. (1) CERTIFICATE OF AUTHORITY. An insurer may apply to the commissioner for a new or amended certificate of authority that limits the insurer to engaging in only the types of insurance business described in sub. (3).

(2) STATEMENT OF OPERATIONS. If an insurer is a cooperative association organized under ss. 185.981 to 185.985, the insurer may apply to the commissioner for a statement of operations that limits the insurer to engaging in only the types of insurance business described in sub. (3).

(3) RESTRICTIONS ON OPERATIONS. (a) An insurer that has a new or amended certificate of authority under sub. (1) or a statement of operations under sub. (2) may engage in only the following types of insurance business:

1. As a health maintenance organization.

2. As a limited service health organization.

3. In other insurance business that is immaterial in relation to, or incidental to, the insurer's business under subd. 1. or 2.

(b) The commissioner may, by rule, define "immaterial" or "incidental", or both, for purposes of par. (a) 3. as a percentage of premiums, except the percentage may not exceed 10 percent of the total premiums written by the insurer.

(4) REMOVING RESTRICTIONS. An amendment to a certificate of authority or statement of operations that removes the limitation imposed under this section is not effective unless the insurer, on the effective date of the amendment, complies with the capital, surplus and other requirements applicable to the insurer under chs. 600 to 645.

History: 1989 a. 23.

Cross-reference: See also s. Ins 9.12, Wis. adm. code.

609.05 Primary provider and referrals. (1) Except as provided in subs. (2) and (3), a limited service health organization, preferred provider plan, or defined network plan shall permit its enrollees to choose freely among participating providers.

(2) Subject to s. 609.22 (4) and (4m), a limited service health organization, preferred provider plan, or defined network plan may require an enrollee to designate a primary provider and to obtain health care services from the primary provider when reasonably possible.

(3) Except as provided in ss. 609.22 (4m), 609.65, and 609.655, a limited service health organization, preferred provider plan, or defined network plan may require an enrollee to obtain a referral from the primary provider designated under sub. (2) to another participating provider prior to obtaining health care services from that participating provider.

History: 1985 a. 29; 1987 a. 366; 1989 a. 121; 1997 a. 237; 1999 a. 9; 2001 a. 16.

609.10 Standard plan and point-of-service option plan required. (1) (ac) In this section, "point-of-service option plan" means a health maintenance organization or preferred provider plan that permits an enrollee to obtain covered health care services from a provider that is not a participating provider of the health maintenance organization or preferred provider plan under all of the following conditions:

1. The nonparticipating provider holds a license or certificate that authorizes or qualifies the provider to provide the health care services.

2. The health maintenance organization or preferred provider plan is required to pay the nonparticipating provider only the

amount that the health maintenance organization or preferred provider plan would pay a participating provider for those health care services.

3. The enrollee is responsible for any additional costs or charges related to the coverage.

(am) Except as provided in subs. (2) to (4), an employer that offers any of its employees a health maintenance organization or a preferred provider plan that provides comprehensive health care services shall also offer the employees a standard plan that provides at least substantially equivalent coverage of health care expenses and a point-of-service option plan, as provided in pars. (b) and (c).

(b) At least once annually, the employer shall provide the employees the opportunity to enroll in the health care plans under par. (am).

(c) The employer shall provide the employees adequate notice of the opportunity to enroll in the health care plans under par. (am) and shall provide the employees complete and understandable information concerning the differences among the health maintenance organization or preferred provider plan, the standard plan and the point-of-service option plan.

(2) If, after providing an opportunity to enroll under sub. (1) (b) and the notice and information under sub. (1) (c), fewer than 25 employees indicate that they wish to enroll in the standard plan under sub. (1) (am), the employer need not offer the standard plan on that occasion.

(3) Subsection (1) does not apply to an employer that does any of the following:

(a) Employs fewer than 25 full-time employees.

(b) Offers its employees a health maintenance organization or a preferred provider plan only through an insurer that is a cooperative association organized under ss. 185.981 to 185.985 or only through an insurer that is restricted under s. 609.03 (3).

(4) Nothing in sub. (1) requires an employer to offer a particular health care plan to an employee if the health care plan determines that the employee does not meet reasonable medical underwriting standards of the health care plan.

(5) The commissioner may establish by rule standards in addition to any established under s. 609.20 for what constitutes adequate notice and complete and understandable information under sub. (1) (c).

(6) The commissioner shall promulgate rules necessary for the administration of the requirement to offer point-of-service option plans under sub. (1) (am).

History: 1985 a. 29; 1997 a. 237; 1999 a. 9; 2001 a. 16.

609.17 Reports of disciplinary action. Every limited service health organization, preferred provider plan, and defined network plan shall notify the medical examining board or appropriate affiliated credentialing board attached to the medical examining board of any disciplinary action taken against a participating provider who holds a license or certificate granted by the board or affiliated credentialing board.

History: 1985 a. 340; 1993 a. 107; 1997 a. 237; 2001 a. 16.

609.20 Rules for preferred provider and defined network plans. (1m) The commissioner may promulgate rules relating to preferred provider plans and defined network plans for any of the following purposes, as appropriate:

(a) To ensure that enrollees are not forced to travel excessive distances to receive health care services.

(b) To ensure that the continuity of patient care for enrollees meets the requirements under s. 609.24.

(c) To define substantially equivalent coverage of health care expenses for purposes of s. 609.10 (1) (am).

(d) To ensure that employees offered a health maintenance organization or a preferred provider plan that provides comprehensive services under s. 609.10 (1) (am) are given adequate notice of the opportunity to enroll, as well as complete and understandable information under s. 609.10 (1) (c) concerning the differences among the health maintenance organization or preferred provider plan, the standard plan and the point-of-service option plan, as defined in s. 609.10 (1) (ac), including differences among providers available and differences resulting from special limitations or requirements imposed by an institutional provider because of its affiliation with a religious organization.

(2m) Any rule promulgated under this chapter shall recognize the differences between preferred provider plans and other types of defined network plans, take into account the fact that preferred provider plans provide coverage for the services of nonparticipating providers, and be appropriate to the type of plan to which the rule applies.

History: 1985 a. 29; 1997 a. 237; 1999 a. 9; 2001 a. 16.

609.205 Public health emergency for COVID-19. (1) In this section, "COVID-19" means an infection caused by the SARS-CoV-2 coronavirus.

(2) All of the following apply to a defined network plan or preferred provider plan during the state of emergency related to public health declared under s. 323.10 on March 12, 2020, by executive order 72, and for the 60 days following the date that the state of emergency terminates:

(a) The plan may not require an enrollee to pay, including cost sharing, for a service, treatment, or supply provided by a provider that is not a participating provider in the plan's network of providers more than the enrollee would pay if the service, treatment, or supply is provided by a provider that is a participating provider. This subsection applies to any service, treatment, or supply that is related to diagnosis or treatment for COVID-19 and to any service, treatment, or supply that is provided by a provider that is not a participating provider because a participating provider is unavailable due to the public health emergency.

(b) The plan shall reimburse a provider that is not a participating provider for a service, treatment, or supply provided under the circumstances described under par. (a) at 225 percent of the rate the federal Medicare program reimburses the provider for the same or a similar service, treatment, or supply in the same geographic area.

(3) During the state of emergency related to public health declared under s. 323.10 on March 12, 2020, by executive order 72, and for the 60 days following the date that the state of emergency terminates, all of the following apply to any health care provider or health care facility that provides a service, treatment, or supply to an enrollee of a defined network plan or preferred provider plan but is not a participating provider of that plan:

(a) The health care provider or facility shall accept as payment in full any payment by a defined network plan or preferred provider plan that is at least 225 percent of the rate the federal Medicare program reimburses the provider for the same or a similar service, treatment, or supply in the same geographic area.

(b) The health care provider or facility may not charge the enrollee for the service, treatment, or supply an amount that exceeds the amount the provider or facility is reimbursed by the defined network plan or preferred provider plan.

(4) The commissioner may promulgate any rules necessary to implement this section.

History: 2019 a. 185.

609.22 Access standards. (1) PROVIDERS. A defined network plan shall include a sufficient number, and sufficient types, of qualified providers to meet the anticipated needs of its en-

rollees, with respect to covered benefits, as appropriate to the type of plan and consistent with normal practices and standards in the geographic area.

(2) ADEQUATE CHOICE. A defined network plan that is not a preferred provider plan shall ensure that, with respect to covered benefits, each enrollee has adequate choice among participating providers and that the providers are accessible and qualified.

(3) PRIMARY PROVIDER SELECTION. A defined network plan that is not a preferred provider plan shall permit each enrollee to select his or her own primary provider from a list of participating primary care physicians and any other participating providers that are authorized by the defined network plan to serve as primary providers. The list shall be updated on an ongoing basis and shall include a sufficient number of primary care physicians and any other participating providers authorized by the plan to serve as primary providers who are accepting new enrollees.

(4) SPECIALIST PROVIDERS. (a) 1. If a defined network plan that is not a preferred provider plan requires a referral to a specialist for coverage of specialist services, the defined network plan that is not a preferred provider plan shall establish a procedure by which an enrollee may apply for a standing referral to a specialist. The procedure must specify the criteria and conditions that must be met in order for an enrollee to obtain a standing referral.

2. A defined network plan that is not a preferred provider plan may require the enrollee's primary provider to remain responsible for coordinating the care of an enrollee who receives a standing referral to a specialist. A defined network plan that is not a preferred provider plan may restrict the specialist from making any secondary referrals without prior approval by the enrollee's primary provider. If an enrollee requests primary care services from a specialist to whom the enrollee has a standing referral, the specialist, in agreement with the enrollee and the enrollee's primary provider, may provide primary care services to the enrollee in accordance with procedures established by the defined network plan that is not a preferred provider plan.

3. A defined network plan that is not a preferred provider plan must include information regarding referral procedures in policies or certificates provided to enrollees and must provide such information to an enrollee or prospective enrollee upon request.

(4m) OBSTETRIC AND GYNECOLOGIC SERVICES. (a) A defined network plan that provides coverage of obstetric or gynecologic services may not require a female enrollee of the defined network plan to obtain a referral for covered obstetric or gynecologic benefits provided by a participating provider who is a physician licensed under ch. 448 and who specializes in obstetrics and gynecology, regardless of whether the participating provider is the enrollee's primary provider. Notwithstanding sub. (4), the defined network plan may not require the enrollee to obtain a standing referral under the procedure established under sub. (4) (a) for covered obstetric or gynecologic benefits.

(b) A defined network plan under par. (a) may not do any of the following:

1. Penalize or restrict the coverage of a female enrollee on account of her having obtained obstetric or gynecologic services in the manner provided under par. (a).

2. Penalize or restrict the contract of a participating provider on account of his or her having provided obstetric or gynecologic services in the manner provided under par. (a).

(c) A defined network plan under par. (a) shall provide written notice of the requirement under par. (a) in every policy or group certificate issued by the defined network plan.

(5) SECOND OPINIONS. A defined network plan shall provide an enrollee with coverage for a 2nd opinion from another participating provider.

(6) EMERGENCY CARE. Notwithstanding s. 632.85, if a defined network plan provides coverage of emergency services, with respect to covered benefits, the defined network plan shall do all of the following:

(a) Cover emergency medical services for which coverage is provided under the plan and that are obtained without prior authorization for the treatment of an emergency medical condition.

(b) Cover emergency medical services or urgent care for which coverage is provided under the plan and that is provided to an individual who has coverage under the plan as a dependent child and who is a full-time student attending school outside of the geographic service area of the plan.

(7) TELEPHONE ACCESS. A defined network plan that is not a preferred provider plan shall provide telephone access for sufficient time during business and evening hours to ensure that enrollees have adequate access to routine health care services for which coverage is provided under the plan. A defined network plan that is not a preferred provider plan shall provide 24-hour telephone access to the plan or to a participating provider for emergency care, or authorization for care, for which coverage is provided under the plan.

(8) ACCESS PLAN FOR CERTAIN ENROLLEES. A defined network plan shall develop an access plan to meet the needs, with respect to covered benefits, of its enrollees who are members of underserved populations. If a significant number of enrollees of the plan customarily use languages other than English, the defined network plan shall provide access to translation services fluent in those languages to the greatest extent possible.

History: 1997 a. 237; 1999 a. 9; 2001 a. 16.

Cross-reference: See also ss. Ins 9.32 and 9.38, Wis. adm. code.

609.24 Continuity of care. (1) REQUIREMENT TO PROVIDE ACCESS. (a) Subject to pars. (b) and (c) and except as provided in par. (d), a defined network plan shall, with respect to covered benefits, provide coverage to an enrollee for the services of a provider, regardless of whether the provider is a participating provider at the time the services are provided, if the defined network plan represented that the provider was, or would be, a participating provider in marketing materials that were provided or available to the enrollee at any of the following times:

1. If the plan under which the enrollee has coverage has an open enrollment period, the most recent open enrollment period.

2. If the plan under which the enrollee has coverage has no open enrollment period, the time of the enrollee's enrollment or most recent coverage renewal, whichever is later.

(b) Except as provided in par. (d), a defined network plan shall provide the coverage required under par. (a) with respect to the services of a provider who is a primary care physician for the following period of time:

1. For an enrollee of a plan with no open enrollment period, until the end of the current plan year.

2. For an enrollee of a plan with an open enrollment period, until the end of the plan year for which it was represented that the provider was, or would be, a participating provider.

(c) Except as provided in par. (d), if an enrollee is undergoing a course of treatment with a participating provider who is not a primary care physician and whose participation with the plan terminates, the defined network plan shall provide the coverage under par. (a) with respect to the services of the provider for the following period of time:

1. Except as provided in subd. 2., for the remainder of the course of treatment or for 90 days after the provider's participation with the plan terminates, whichever is shorter, except that the

coverage is not required to extend beyond the period specified in par. (b) 1. or 2., whichever applies.

2. If maternity care is the course of treatment and the enrollee is a woman who is in the 2nd or 3rd trimester of pregnancy when the provider's participation with the plan terminates, until the completion of postpartum care for the woman and infant.

(d) The coverage required under this section need not be provided or may be discontinued if any of the following applies:

1. The provider no longer practices in the defined network plan's geographic service area.

2. The insurer issuing the defined network plan terminates or terminated the provider's contract for misconduct on the part of the provider.

(e) 1. An insurer issuing a defined network plan shall include in its provider contracts provisions addressing reimbursement to providers for services rendered under this section.

2. If a contract between a defined network plan and a provider does not address reimbursement for services rendered under this section, the insurer shall reimburse the provider according to the most recent contracted rate.

(2) MEDICAL NECESSITY PROVISIONS. This section does not preclude the application of any provisions related to medical necessity that are generally applicable under the plan.

(3) HOLD HARMLESS REQUIREMENTS. A provider that receives or is due reimbursement for services provided to an enrollee under this section is subject to s. 609.91 with respect to the enrollee, regardless of whether the provider is a participating provider in the enrollee's plan and regardless of whether the enrollee's plan is a health maintenance organization.

(4) NOTICE OF PROVISIONS. A defined network plan shall notify all plan enrollees of the provisions under this section whenever a participating provider's participation with the plan terminates, or shall, by contract, require a participating provider to notify all plan enrollees of the provisions under this section if the participating provider's participation with the plan terminates.

History: 1997 a. 237; 2001 a. 16.
Cross-reference: See also s. Ins 9.35, Wis. adm. code.

609.28 Dental provider network rental. (1) A defined network plan, preferred provider plan, limited service health organization, or other insurer that offers coverage of dental services, has a network of participating dental service providers, and engages in the practice of renting its network of participating dental service providers to other entities shall do all of the following:

(a) Include in any contract with a dental service provider entered into, modified, or renewed more than 30 days after April 10, 2026, a notification that the plan, organization, or insurer engages in the practice of network rental and a list of all current entities to which the network may be rented.

(b) Notify a dental service provider, electronically or in writing, that the plan, organization, or insurer has entered into an agreement with an entity under which the dental service provider's contract is rented to the entity. The notification under this paragraph shall identify the entity and be provided within 45 days of the date of the rental of the contract on which the plan, organization, or insurer enters into the agreement.

(2) Any person who obtains a network of participating dental service providers through rental from a defined network plan, preferred provider plan, limited service health organization, or other insurer shall abide by all terms and conditions of the original contract, including discounted rates or fees, between a dental service provider and the plan, organization, or insurer.

(3) A dental service provider whose contract has been rented to another entity may terminate their participation in the contract with the entity without terminating the original contract with the defined network plan, preferred provider plan, limited service health organization, or other insurer.

History: 2025 a. 229.

609.30 Provider disclosures. (1) PLAN MAY NOT CONTRACT. A defined network plan may not contract with a participating provider to limit the provider's disclosure of information, to or on behalf of an enrollee, about the enrollee's medical condition or treatment options.

(2) PLAN MAY NOT PENALIZE OR TERMINATE. A participating provider may discuss, with or on behalf of an enrollee, all treatment options and any other information that the provider determines to be in the best interest of the enrollee. A defined network plan may not penalize or terminate the contract of a participating provider because the provider makes referrals to other participating providers or discusses medically necessary or appropriate care with or on behalf of an enrollee.

History: 1997 a. 237; 2001 a. 16.

609.32 Quality assurance. (1) STANDARDS; OTHER THAN PREFERRED PROVIDER PLANS. A defined network plan that is not a preferred provider plan shall develop comprehensive quality assurance standards that are adequate to identify, evaluate, and remedy problems related to access to, and continuity and quality of, care. The standards shall include at least all of the following:

(a) An ongoing, written internal quality assurance program.

(b) Specific written guidelines for quality of care studies and monitoring.

(c) Performance and clinical outcomes-based criteria.

(d) A procedure for remedial action to address quality problems, including written procedures for taking appropriate corrective action.

(e) A plan for gathering and assessing data.

(f) A peer review process.

(1m) PROCEDURE FOR REMEDIAL ACTION; PREFERRED PROVIDER PLANS. A preferred provider plan shall develop a procedure for remedial action to address quality problems, including written procedures for taking appropriate corrective action.

(2) SELECTION AND EVALUATION OF PROVIDERS. (a) A defined network plan shall develop a process for selecting participating providers, including written policies and procedures that the plan uses for review and approval of providers. After consulting with appropriately qualified providers, the plan shall establish minimum professional requirements for its participating providers. The process for selection shall include verification of a provider's license or certificate, including the history of any suspensions or revocations, and the history of any liability claims made against the provider.

(b) A defined network plan shall establish in writing a formal, ongoing process for reevaluating each participating provider within a specified number of years after the provider's initial acceptance for participation. The reevaluation shall include all of the following:

1. Updating the previous review criteria.

2. Assessing the provider's performance on the basis of such criteria as enrollee clinical outcomes, number of complaints and malpractice actions.

(c) A defined network plan may not require a participating provider to provide services that are outside the scope of his or her license or certificate.

History: 1997 a. 237; 2001 a. 16.
Cross-reference: See also s. Ins 9.40, Wis. adm. code.

609.34 Clinical decision-making; medical director. (1) A defined network plan that is not a preferred provider plan shall appoint a physician as medical director. The medical direc-

tor shall be responsible for clinical protocols, quality assurance activities, and utilization management policies of the plan.

(2) A preferred provider plan may contract for services related to clinical protocols and utilization management. A preferred provider plan or its designee is required to appoint a medical director only to the extent that the preferred provider plan or its designee assumes direct responsibility for clinical protocols and utilization management policies of the plan. The medical director, who shall be a physician, shall be responsible for such protocols and policies of the plan.

History: 1997 a. 237; 2001 a. 16.

609.35 Applicability of requirements to preferred provider plans. Notwithstanding ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), a preferred provider plan that does not cover the same services when performed by a nonparticipating provider that it covers when those services are performed by a participating provider is subject to the requirements under ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1).

History: 2001 a. 16.

609.36 Data systems and confidentiality. (1) INFORMATION AND DATA REPORTING. (a) A defined network plan shall provide to the commissioner information related to all of the following:

1. The structure of the plan.
2. Health care benefits and exclusions.
3. Cost-sharing requirements.
4. Participating providers.

(b) Subject to sub. (2), the information and data reported under par. (a) shall be open to public inspection under ss. 19.31 to 19.39.

(2) CONFIDENTIALITY. A defined network plan shall establish written policies and procedures, consistent with ss. 51.30, 146.82, and 252.15, for the handling of medical records and enrollee communications to ensure confidentiality.

History: 1997 a. 237; 2001 a. 16.

609.38 Oversight. The office shall perform examinations of insurers that issue defined network plans consistent with ss. 601.43 and 601.44. The commissioner shall by rule develop standards for defined network plans for compliance with the requirements under this chapter.

History: 1997 a. 237; 2001 a. 16.

609.60 Optometric coverage. Health maintenance organizations and preferred provider plans are subject to s. 632.87 (2m).

History: 1985 a. 29.

609.65 Coverage for court-ordered services for the mentally ill. (1) If an enrollee of a limited service health organization, preferred provider plan, or defined network plan is examined, evaluated, or treated for a nervous or mental disorder pursuant to a court order under s. 880.33 (4m) or (4r), 2003 stats., an emergency detention under s. 51.15, a commitment or a court order under s. 51.20, an order for protective placement or protective services under ch. 55, an order under s. 55.14 or 55.19 (3) (e), or an order under ch. 980, then, notwithstanding the limitations regarding participating providers, primary providers, and referrals under ss. 609.01 (2) to (4) and 609.05 (3), the limited service health organization, preferred provider plan, or defined network plan shall do all of the following:

(a) If the provider performing the examination, evaluation, or treatment has a provider agreement with the limited service health organization, preferred provider plan, or defined network plan which covers the provision of that service to the enrollee, make the service available to the enrollee in accordance with the terms of the limited service health organization, preferred provider plan, or defined network plan and the provider agreement.

(b) If the provider performing the examination, evaluation or treatment does not have a provider agreement with the limited service health organization, preferred provider plan, or defined network plan which covers the provision of that service to the enrollee, reimburse the provider for the examination, evaluation, or treatment of the enrollee in an amount not to exceed the maximum reimbursement for the service under the medical assistance program under subch. IV of ch. 49, if any of the following applies:

1. The service is provided pursuant to a commitment or a court order, except that reimbursement is not required under this subdivision if the limited service health organization, preferred provider plan, or defined network plan could have provided the service through a provider with whom it has a provider agreement.

2. The service is provided pursuant to an emergency detention under s. 51.15 or on an emergency basis to a person who is committed under s. 51.20 and the provider notifies the limited service health organization, preferred provider plan, or defined network plan within 72 hours after the initial provision of the service.

(2) If after receiving notice under sub. (1) (b) 2. the limited service health organization, preferred provider plan, or defined network plan arranges for services to be provided by a provider with whom it has a provider agreement, the limited service health organization, preferred provider plan, or plan is not required to reimburse a provider under sub. (1) (b) 2. for any services provided after arrangements are made under this subsection.

(3) A limited service health organization, preferred provider plan, or defined network plan is only required to make available, or make reimbursement for, an examination, evaluation, or treatment under sub. (1) to the extent that the limited service health organization, preferred provider plan, or defined network plan would have made the medically necessary service available to the enrollee or reimbursed the provider for the service if any referrals required under s. 609.05 (3) had been made and the service had been performed by a participating provider.

History: 1987 a. 366; 1993 a. 316, 479; 1995 a. 27; 1997 a. 237; 2001 a. 16; 2005 a. 264, 387; 2007 a. 45.

609.655 Coverage of certain services provided to dependent students. (1) In this section:

(a) "Dependent student" means an individual who satisfies all of the following:

1. Is covered as a dependent child under the terms of a policy or certificate issued by a defined network plan insurer.

2. Is enrolled in a school located in this state but outside the geographical service area of the defined network plan.

(b) "Outpatient services" has the meaning given in s. 632.89 (1) (e).

(c) "School" means a technical college; an institution within the University of Wisconsin System; and any institution of higher education that grants a bachelor's or higher degree.

(2) If a policy or certificate issued by a defined network plan insurer provides coverage of outpatient services provided to a dependent student, the policy or certificate shall provide coverage of outpatient services, to the extent and in the manner required under sub. (3), that are provided to the dependent student while he or she is attending a school located in this state but outside the geographical service area of the defined network plan, notwithstanding the limitations regarding participating providers, primary providers, and referrals under ss. 609.01 (2) and 609.05 (3).

(3) Except as provided in sub. (5), a defined network plan shall provide coverage for all of the following services:

(a) A clinical assessment of the dependent student's nervous or mental disorders or alcoholism or other drug abuse problems, conducted by a provider described in s. 632.89 (1) (e) 2., 3., or 4. who is located in this state and in reasonably close proximity to the school in which the dependent student is enrolled and who may be designated by the defined network plan.

(b) If outpatient services are recommended in the clinical assessment conducted under par. (a), the recommended outpatient services consisting of not more than 5 visits to an outpatient treatment facility or other provider that is located in this state and in reasonably close proximity to the school in which the dependent student is enrolled and that may be designated by the defined network plan, except as follows:

1. Coverage is not required under this paragraph if the medical director of the defined network plan determines that the nature of the treatment recommended in the clinical assessment will prohibit the dependent student from attending school on a regular basis.

2. Coverage is not required under this paragraph for outpatient services provided after the dependent student has terminated his or her enrollment in the school.

(4) (a) Upon completion of the 5 visits for outpatient services covered under sub. (3) (b), the medical director of the defined network plan and the clinician treating the dependent student shall review the dependent student's condition and determine whether it is appropriate to continue treatment of the dependent student's nervous or mental disorders or alcoholism or other drug abuse problems in reasonably close proximity to the school in which the student is enrolled. The review is not required if the dependent student is no longer enrolled in the school or if the coverage limits under the policy or certificate for treatment of nervous or mental disorders or alcoholism or other drug abuse problems have been exhausted.

(b) Upon completion of the review under par. (a), the medical director of the defined network plan shall determine whether the policy or certificate will provide coverage of any further treatment for the dependent student's nervous or mental disorder or alcoholism or other drug abuse problems that is provided by a provider located in reasonably close proximity to the school in which the student is enrolled. If the dependent student disputes the medical director's determination, the dependent student may submit a written grievance under the defined network plan's internal grievance procedure established under s. 632.83.

(5) (a) A policy or certificate issued by a defined network plan insurer is required to provide coverage for the services specified in sub. (3) only to the extent that the policy or certificate would have covered the service if it had been provided to the dependent student by a participating provider within the geographical service area of the defined network plan.

(b) Paragraph (a) does not permit a defined network plan to reimburse a provider for less than the full cost of the services provided or an amount negotiated with the provider, solely because the reimbursement rate for the service would have been less if provided by a participating provider within the geographical service area of the defined network plan.

History: 1989 a. 121; 1993 a. 399; 1997 a. 237; 1999 a. 155; 2001 a. 16; 2009 a. 28.

609.70 Chiropractic coverage. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.87 (3).

History: 1987 a. 27; 1997 a. 237; 2001 a. 16.

609.71 Disclosure of payments. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.798.

History: 2009 a. 146.

609.715 Coverage of alcoholism and other diseases. Defined network plans are subject to s. 632.89.

History: 2009 a. 218 s. 14; 2011 a. 260 s. 80.

609.717 Mental health services provided by a recovery charter school. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.87 (4m).

History: 2017 a. 30.

609.75 Adopted children coverage. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.896. Coverage of health care services obtained by adopted children and children placed for adoption may be subject to any requirements that the limited service health organization, preferred provider plan, or defined network plan imposes under s. 609.05 (2) and (3) on the coverage of health care services obtained by other enrollees.

History: 1989 a. 336; 1997 a. 237; 2001 a. 16.

609.755 Coverage of dependents. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.885.

History: 2009 a. 28.

609.76 Coverage of student on medical leave. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.895 (15).

History: 2007 a. 36.

609.77 Coverage of breast reconstruction. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.895 (13).

History: 1997 a. 27, 237; 2001 a. 16.

609.78 Coverage of treatment for the correction of temporomandibular disorders. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.895 (11).

History: 1997 a. 27, 237; 2001 a. 16.

609.79 Coverage of hospital and ambulatory surgery center charges and anesthetics for dental care. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.895 (12).

History: 1997 a. 27, 237; 2001 a. 16.

609.80 Coverage of mammograms. Defined network plans and preferred provider plans are subject to s. 632.895 (8). Coverage of mammograms under s. 632.895 (8) may be subject to any requirements that the defined network plan or preferred provider plan imposes under s. 609.05 (2) and (3) on the coverage of other health care services obtained by enrollees.

History: 1989 a. 129; 1997 a. 237; 2001 a. 16; 2025 a. 103.

609.805 Coverage of contraceptives. Defined network plans are subject to s. 632.895 (17).

History: 2009 a. 28.

609.81 Coverage related to HIV infection. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 631.93. Defined network plans are subject to s. 632.895 (9).

History: 1989 a. 201; 1989 a. 359 s. 389; 1997 a. 237; 2001 a. 16.

609.82 Coverage without prior authorization for emergency medical condition treatment. Limited service

health organizations, preferred provider plans, and defined network plans are subject to s. 632.85.

History: 1997 a. 237; 2001 a. 16.

609.83 Coverage of drugs and devices. Limited service health organizations, preferred provider plans, and defined network plans are subject to ss. 632.853, 632.861, and 632.895 (16t) and (16v).

History: 1997 a. 237; 2001 a. 16; 2017 a. 305; 2019 a. 185; 2021 a. 9.

609.837 Copayment equality for oral and injected chemotherapy. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.867.

History: 2013 a. 186.

609.84 Experimental treatment. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.855.

History: 1997 a. 237; 2001 a. 16.

609.846 Discrimination based on COVID-19 prohibited. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.729.

History: 2019 a. 185.

609.85 Coverage of lead screening. Health maintenance organizations and preferred provider plans are subject to s. 632.895 (10).

History: 1993 a. 450.

609.86 Coverage of hearing aids, cochlear implants, and related treatment for infants and children. Defined network plans are subject to s. 632.895 (16).

History: 2009 a. 14.

609.87 Coverage of treatment for autism spectrum disorders. Defined network plans are subject to s. 632.895 (12m).

History: 2009 a. 28.

609.875 Coverage of colorectal cancer screening. Defined network plans are subject to s. 632.895 (16m).

History: 2009 a. 346 s. 8; 2011 a. 260 s. 80.

609.88 Coverage of immunizations. Defined network plans are subject to s. 632.895 (14).

History: 1999 a. 115; 2001 a. 16.

609.885 Coverage of COVID-19 testing. Defined network plans, preferred provider plans, and limited service health organizations are subject to s. 632.895 (14g).

History: 2019 a. 185.

609.89 Written reason for coverage denial. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 631.17.

History: 1999 a. 95; 2001 a. 16.

609.90 Restrictions related to domestic abuse. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 631.95.

History: 1999 a. 95; 2001 a. 16.

609.91 Restrictions on recovering health care costs.

(1) IMMUNITY OF ENROLLEES AND POLICYHOLDERS. Except as provided in sub. (1m) or (1p), an enrollee or policyholder of a health maintenance organization insurer is not liable for health care costs that are incurred on or after January 1, 1990, and that are covered under a policy or certificate issued by the health maintenance organization insurer, if any of the following applies:

(a) The health care is provided by a provider who satisfies any of the following:

1. Is an affiliate of the health maintenance organization insurer.

2. Owns at least 5 percent of the voting securities of the health maintenance organization insurer.

3. Is entitled, alone or with one or more affiliates, to solely select one or more board members of the health maintenance organization insurer, or has an affiliate that is entitled to solely select one or more board members of the health maintenance organization insurer.

4. Is entitled to have one or more board members of the health maintenance organization insurer serve exclusively as a representative of the provider, one or more of the provider's affiliates or the provider and its affiliates, except this subdivision does not apply to an individual practice association or an affiliate of an individual practice association.

5. Is an individual practice association that is represented, or its affiliate is represented, on the board of the health maintenance organization insurer, and at least 3 of the board members of the health maintenance organization represent one or more individual practice associations.

(am) The health care is provided by a provider under a contract with, or through membership in, a person who satisfies par. (a) 1., 2., 3., 4. or 5.

(b) The health care is provided by a provider who is not subject to par. (a) or (am) and who does not elect to be exempt from this paragraph under s. 609.92, and the health care satisfies any of the following:

1. Is provided by a hospital or an individual practice association.

2. Is physician services provided under a contract with the health maintenance organization insurer or by a participating provider of the health maintenance organization insurer.

3. Is services, equipment, supplies or drugs that are ancillary or incidental to services described in subd. 2. and are provided by the contracting provider or participating provider.

(c) The health care is provided by a provider who is not subject to par. (a), (am) or (b) with regard to that health care and who elects under s. 609.925 to be subject to this paragraph.

(d) The liability is for the portion of health care costs that exceeds the amount that the health maintenance organization insurer has agreed, in a contract with the provider of the health care, to pay the provider for that health care.

(1m) IMMUNITY OF MEDICAL ASSISTANCE RECIPIENTS. An enrollee, policyholder or insured under a policy issued by an insurer to the department of health services under s. 49.45 (2) (b) 2. to provide prepaid health care to medical assistance recipients is not liable for health care costs that are covered under the policy.

(1p) IMMUNITY FOR CERTAIN MEDICARE RECIPIENTS. An enrollee, policyholder, or insured under a policy issued by an insurer under Part C of Medicare under 42 USC 1395w-21 to 1395w-28 or Part D of Medicare under 42 USC 1395w-101 to 1395w-152 to provide prepaid health care, fee-for-service health care, or drug benefits to enrollees of Part C or Part D of Medicare is not liable for health care costs that are covered under the policy.

(2) PROHIBITED RECOVERY ATTEMPTS. No person may bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency or have any recourse against an enrollee, policyholder or insured, or any person acting on their behalf, for health care costs for which the enrollee, policyholder or insured, or person acting on their behalf, is not liable under sub. (1), (1m), or (1p).

(3) DEDUCTIBLES, COPAYMENTS AND PREMIUMS. Subsec-

tions (1) to (2) do not affect the liability of an enrollee, policyholder or insured for any deductibles, copayments or premiums owed under the policy or certificate issued by the health maintenance organization insurer or by the insurer described in sub. (1m) or (1p).

(4) CONDITIONS NOT AFFECTING THE IMMUNITY. The immunity of an enrollee, policyholder or insured for health care costs, to the extent of the immunity provided under this section and ss. 609.92 to 609.935, is not affected by any of the following:

(a) An agreement, other than a notice of election or termination of election in accordance with s. 609.92 or 609.925, entered into by the provider, the health maintenance organization insurer, the insurer described in sub. (1m) or (1p) or any other person, at any time, whether oral or written and whether implied or explicit, including an agreement that purports to hold the enrollee, policyholder or insured liable for health care costs.

(b) A breach of or default on an agreement by the health maintenance organization insurer, the insurer described in sub. (1m) or (1p) or any other person to compensate the provider, directly or indirectly, for health care costs, including health care costs for which the enrollee, policyholder or insured is not liable under sub. (1), (1m), or (1p).

(c) The insolvency of the health maintenance organization insurer or any person contracting with the health maintenance organization insurer or provider, or the commencement or the existence of conditions permitting the commencement of insolvency, delinquency or bankruptcy proceedings involving the health maintenance organization insurer or other person, including delinquency proceedings, as defined in s. 645.03 (1) (b), under ch. 645, despite whether the health maintenance organization insurer or other person has agreed to compensate, directly or indirectly, the provider for health care costs for which the enrollee or policyholder is not liable under sub. (1).

(cm) The insolvency of the insurer described in sub. (1m) or (1p) or any person contracting with the insurer or provider, or the commencement or the existence of conditions permitting the commencement of insolvency, delinquency or bankruptcy proceedings involving the insurer or other person, including delinquency proceedings, as defined in s. 645.03 (1) (b), under ch. 645, despite whether the insurer or other person has agreed to compensate, directly or indirectly, the provider for health care costs for which the enrollee, policyholder or insured is not liable under sub. (1m) or (1p).

(d) The inability of the provider or other person who is owed compensation for health care costs to obtain compensation from the health maintenance organization insurer, the insurer described in sub. (1m) or (1p), or any other person for health care costs for which the enrollee, policyholder or insured is not liable under sub. (1), (1m), or (1p).

(e) The failure of a health maintenance organization insurer to comply with s. 609.94.

(f) Any other conditions or agreements, other than a notice of election or termination of election in accordance with s. 609.92 or 609.925, existing at any time.

History: 1989 a. 23; 1995 a. 27 s. 9126 (19); 1997 a. 237; 2007 a. 20 s. 9121 (6) (a); 2009 a. 342.

Sections 609.01 and 609.91 do not prohibit HMOs from asserting contractual subrogation rights with respect to actual medical expenses incurred by an HMO for medical care covered by the HMO's contract with an enrollee. This section is replete with language immunizing enrollees and limiting their liability, but does not speak to the sources of funds available to HMOs, except to the extent that it limits funds HMOs may obtain from enrollees. Torres v. Dean Health Plan, Inc. 2005 WI App 89, 282 Wis. 2d 725, 698 N.W.2d 107, 03-3274.

609.92 Hospitals, individual practice associations and providers of physician services. (1) ELECTION OF EXEMPTION. Except as provided in s. 609.93, a hospital, an individual practice association or other provider described in s. 609.91 (1) (b) may elect to be exempt from s. 609.91 (1) (b) for the purpose of recovering health care costs arising from health care provided by the hospital, individual practice association or other provider, if the conditions under sub. (2) or (3), whichever is applicable, are satisfied.

(2) CARE PROVIDED UNDER A CONTRACT. If the health care is provided under a written contract between a health maintenance organization insurer and the hospital, individual practice association or other provider, all of the following conditions must be met for the hospital, individual practice association or other provider to secure an exemption under sub. (1):

(a) The contract must be in effect on the date that the health care is provided, and the health care must be provided in accordance with the terms of the contract.

(b) The hospital, individual practice association or other provider must, within 30 days after entering into the contract, deliver to the office a written notice stating that the hospital, individual practice association or other provider elects to be exempt from s. 609.91 (1) (b). The notice shall comply with the rules, if any, promulgated under s. 609.935.

(3) CARE PROVIDED WITHOUT A CONTRACT. If the health care is not provided under a contract that satisfies sub. (2), all of the following conditions must be met for the hospital, individual practice association or other provider to secure an exemption under sub. (1):

(a) The hospital, individual practice association or other provider must deliver to the office a notice stating that the hospital, individual practice association or other provider elects to be exempt from s. 609.91 (1) (b) with respect to a specified health maintenance organization insurer. The notice shall comply with the rules, if any, promulgated under s. 609.935.

(b) If the health care is provided on or after January 1, 1990, and before January 1, 1991, the health care must be provided at least 60 days after the office receives the notice under par. (a).

(c) If the health care is provided on or after January 1, 1991, the health care must be provided at least 90 days after the office receives the notice under par. (a).

(4) TERMINATION OF ELECTION. A hospital, individual practice association or other provider may terminate its election under sub. (2) or (3) by stating the termination date in the notice under sub. (2) or (3) or in a separate written termination notice filed with the office. The termination notice shall comply with the rules, if any, promulgated under s. 609.935. The termination is effective for any health care costs incurred after the termination date specified in the notice or the date on which the notice is filed, whichever is later.

(5) PROVIDER OF PHYSICIAN SERVICES. A provider who is not under contract with a health maintenance organization insurer and who is not a participating provider of a health maintenance organization insurer is not subject to s. 609.91 (1) (b) 2. with respect to health care costs incurred by an enrollee of that health maintenance organization insurer.

History: 1989 a. 23; 1997 a. 237.

609.925 Election to be subject to restrictions. (1) NOTICE OF ELECTION. Except as provided in s. 609.93, a provider described in s. 609.91 (1) (c) is subject to s. 609.91 (1) (c) for purposes of recovering health care costs arising from health care provided by the provider, if the provider files with the office a written notice stating that the provider elects to be subject to s. 609.91 (1) (c) with respect to a specified health maintenance organization insurer. The notice shall comply with the rules, if any, promulgated under s. 609.935. The notice is effective on the date that it is received by the office or the date specified in the notice, whichever is later.

(2) TERMINATION OF ELECTION. A provider may terminate a notice of election under sub. (1) by stating the termination date in the notice of election or in a separate written termination notice filed with the office. The termination notice shall comply with the rules, if any, promulgated under s. 609.935. The termination date may not be earlier than 90 days after the office receives notice of termination, whether included in the notice of election or in a separate termination notice.

(3) EFFECTIVE PERIOD OF ELECTION. Section 609.91 applies to health care costs incurred on and after the effective date of the notice under sub. (1) or January 1, 1990, whichever is later, and until the termination date of the notice.

History: 1989 a. 23.

609.93 Scope of election by an individual practice association or clinic. (1) INDIVIDUAL PRACTICE ASSOCIATION. The election by an individual practice association under s. 609.92 to be exempt from s. 609.91 (1) (b) or the failure of the individual practice association to so elect applies to health care costs arising from health care provided by any provider, other than a hospital, under a contract with, or through membership in, the individual practice association. A provider, other than a hospital, may not exercise an election under s. 609.92 or 609.925 separately from an individual practice association with respect to health care costs arising from health care provided under a contract with, or through membership in, the individual practice association.

(2) CLINICS. (a) The election by a clinic under s. 609.92 to be exempt from s. 609.91 (1) (b) with respect to services described in s. 609.91 (1) (b) 2. and 3. or the failure of the clinic to so elect, or the election by a clinic under s. 609.925 to be subject to s. 609.91 (1) (c) or the failure of the clinic to so elect, applies to health care costs arising from health care provided by any provider through the clinic. A provider may not exercise an election under s. 609.92 or 609.925 separately from the clinic with respect to health care costs provided through the clinic.

(b) The commissioner may, by rule, specify the types of health care facilities or organizations that qualify as clinics for purposes of this subsection.

History: 1989 a. 23.

609.935 Notices of election and termination. (1) IN ACCORDANCE WITH RULES. If the commissioner promulgates rules governing the form or manner of filing a notice of election or termination notice under s. 609.92 or 609.925, a notice of election or termination notice filed after the rules take effect is not effective unless filed in accordance with the applicable rules.

(2) EFFECT OF CERTAIN CHANGES. The effectiveness of a notice of election or termination notice filed with the office under s. 609.92 or 609.925 is not affected by the renaming, reorganization, merger, consolidation or change in control of the provider, health maintenance organization insurer or any other person. The commissioner may, by rule, require a provider to amend a notice of election or termination notice if any of the events in this subsection or other changes affecting the accuracy of the information occur.

History: 1989 a. 23.

609.94 Summary of restrictions. (1) A health maintenance organization insurer shall deliver a written notice that complies with sub. (2) to all of the following:

(a) Each provider that contracts with the health maintenance organization insurer to provide health care services, at the time that the health maintenance organization insurer and provider enter into a contract.

(b) Each participating provider of the health maintenance organization insurer, at the time that the provider becomes a participating provider.

(2) The notice shall contain a summary of ss. 609.91 to 609.935 and 609.97 (1) and a statement that the health maintenance organization insurer files financial statements with the office which are available for public inspection. The commissioner may, by rule, specify a form for providing the notice required under this section. If the commissioner promulgates such a rule, any notice delivered on or after the effective date of the rule shall comply with the form specified by rule.

History: 1989 a. 23; 1997 a. 237.

Cross-reference: See also s. Ins 9.13, Wis. adm. code.

609.95 Minimum covered liabilities. A health maintenance organization insurer, whether first licensed or organized before, on or after July 1, 1989, shall maintain, on and after January 1, 1990, at least 65 percent of its liabilities for health care costs as covered liabilities.

History: 1989 a. 23.

609.96 Initial capital and surplus requirements. (1) MINIMUM CAPITAL AND PERMANENT SURPLUS. (a) Except as provided in par. (b), if a health maintenance organization insurer is first licensed or organized on or after July 1, 1989, the minimum capital or permanent surplus for the health maintenance organization insurer is $750,000.

(b) The commissioner may require a greater amount or permit a lesser amount than that specified under sub. (1) by rule promulgated, or order issued, on or after July 1, 1989.

(2) INITIAL EXPENDABLE SURPLUS. A health maintenance organization insurer subject to sub. (1) shall have an initial expendable surplus, after payment of all organizational expenses, of at least 50 percent of the minimum capital or minimum permanent surplus required under sub. (1), or such other percentage as the commissioner specifies by rule promulgated, or order issued, on or after July 1, 1989.

History: 1989 a. 23.

609.97 Compulsory and security surplus. (1) AMOUNT OF COMPULSORY SURPLUS. Except as otherwise provided by rule or order under sub. (2), a health maintenance organization insurer, whether first licensed or organized before, on or after July 1, 1989, shall maintain a compulsory surplus in an amount determined as follows:

(a) Beginning on July 1, 1989, and ending on December 31, 1989, the compulsory surplus shall be equal to at least the greater of $200,000 or 3 percent of the premiums earned by the health maintenance organization insurer in the previous 12 months.

(b) Beginning on January 1, 1990, and ending on December 31, 1991, the compulsory surplus shall be equal to at least the greater of $500,000 or:

1. If before January 1, 1991, 3 percent of the premiums earned by the health maintenance organization insurer in the previous 12 months.

2. If on or after January 1, 1991:

a. If the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is less than 90 percent, 4.5 percent of the premiums earned by the health maintenance organization insurer in the previous 12 months.

b. If the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is at least 90 percent, 3 percent of the premiums earned by the health maintenance organization insurer in the previous 12 months.

(c) Beginning on January 1, 1992, the compulsory surplus shall be equal to at least the greater of $750,000 or:

1. If the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is less than

90 percent, 6 percent of the premiums earned by the health maintenance organization insurer in the previous 12 months.

2. If the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is at least 90 percent, 3 percent of the premiums earned by the health maintenance organization insurer in the previous 12 months.

(2) MODIFICATION BY RULE OR ORDER. The commissioner may require a greater amount or permit a lesser amount than that specified under sub. (1) by rule promulgated, or order issued, on or after July 1, 1989. The commissioner may consider the risks and factors described under s. 623.11 (1) (a) and (b) in promulgating a rule or issuing an order under this subsection.

(3) AMOUNT OF SECURITY SURPLUS. A health maintenance organization insurer, whether first licensed or organized before, on or after July 1, 1989, shall maintain a security surplus in the amount set by the commissioner under s. 623.12.

History: 1989 a. 23.

609.98 Special deposit. (1) DEFINITION. In this section, "premiums" has the meaning given under s. 646.51 (1c) (c).

(2) DUTY; AMOUNT. (a) Before April 1, 1990, and before April 1 of each following year, a health maintenance organization insurer shall deposit under s. 601.13 an amount that is at least equal to the lesser of the following:

1. An amount necessary to establish or maintain a deposit equaling 1 percent of premiums written in this state by the health maintenance organization insurer in the preceding calendar year.

2. With respect to the amount due before April 1, 1990, 0.5 percent of premiums written in this state by the health maintenance organization insurer in the preceding calendar year, unless otherwise provided by rule or order under par. (b).

3. With respect to the amount due in the years after 1990, one-third of 1 percent of the premiums written in this state by the health maintenance organization insurer in the preceding calendar year, unless otherwise provided by rule or order under par. (b).

(b) The commissioner may, by rule or order, require that the deposit under par. (a) be in an amount greater than that provided under par. (a) 2. or 3., but the commissioner may not require an amount exceeding the amount provided under par. (a) 1.

(3) STATUS OF DEPOSIT. A deposit under this section is in addition to any deposit otherwise required or permitted by law or the commissioner. An amount deposited under this section is not available for the purpose of determining permanent capital or surplus, compulsory surplus or the financial condition, including insolvency, of the health maintenance organization insurer.

(4) RELEASE OF DEPOSIT. A deposit under this section may be released only with the approval of the commissioner under s. 601.13 (10) and only in any of the following circumstances:

(a) To pay an assessment under s. 646.51 (3) (am).

(b) To the extent that the amount on deposit exceeds 1 percent of premiums written in this state by the health maintenance organization insurer in the preceding calendar year and the deposit is not necessary to pay an assessment under s. 646.51 (3) (am).

(c) To pay claimants and creditors as provided by s. 601.13 (2).

(5) FAMILY CARE PROGRAM; DEPOSIT REQUIRED. (a) In this subsection, "family care program" means the program under ss. 46.2805 to 46.2895 that provides the family care benefit, as defined in s. 46.2805 (4).

(b) A health maintenance organization participating in the family care program is subject to s. 648.75.

History: 1989 a. 23; 2003 a. 261; 2023 a. 212.