CHAPTER 609

HEALTH MAINTENANCE ORGANIZATIONS, LIMITED SERVICE HEALTH ORGANIZATIONS AND PREFERRED PROVIDER PLANS

Cross−reference: See definitions in ss. 600.03 and 628.02.

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 employes 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:

(1) "Covered liability" means liability of a health maintenance organization insurer for health care costs for which an enrolled participant or policyholder of the health maintenance organization insurer is not liable to any person under s. 609.91.

(1d) "Enrolled participant" means a person entitled to health care services under an individual or group policy issued by a health maintenance organization, limited service health organization or preferred provider plan.

(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, 611, 613 or 614 or issued a certificate of authority under ch. 618 that makes available to its enrolled participants, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers selected by the organization.

(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 enrolled participants, in consideration for predetermined periodic fixed payments, a limited range of health care services performed by providers selected by the organization.

(4) "Preferred provider plan" 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 enrolled participants, for consideration other than predetermined periodic fixed payments, either comprehensive health care services or a limited range of health care services performed by providers selected by the organization.

(5) "Primary provider" means a selected provider who is an individual and who is designated by an enrolled participant.

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

(6) "Selected provider" means a provider selected by a health maintenance organization, limited service health organization or preferred provider plan to perform health care services for enrolled participants.

(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.

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% 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.

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

(2) A health care plan under sub. (1) may require an enrolled participant to designate a primary provider and to obtain health care services from the primary provider when reasonably possible.

(3) Except as provided in ss. 609.65 and 609.655, a health care plan under sub. (1) may require an enrolled participant to obtain a referral from the primary provider designated under sub. (2) to another selected provider prior to obtaining health care services from the other selected provider.

History: 1985 a. 29; 1987 a. 366; 1989 a. 121.

609.10 Standard plan required. (1) (a) Except as provided in subs. (2) to (4), an employer that offers any of its employes a health maintenance organization or a preferred provider plan that provides comprehensive health care services shall also offer the employes a standard plan, as provided in pars. (b) and (c), that provides at least substantially equivalent coverage of health care expenses and that is not a health maintenance organization or a preferred provider plan.

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

(c) The employer shall provide the employes adequate notice of the opportunity to enroll in the health care plans under par. (a) and shall provide the employes complete and understandable information concerning the differences between the health maintenance organization or preferred provider plan and the standard 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 employes indicate that they wish to enroll in the standard plan under sub. (1) (a), the employer need not offer the standard plan on that occasion.

(3) Subsection (1) does not apply to an employer that employs fewer than 25 full−time employes.

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

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

History: 1985 a. 29.

609.15 Grievance procedure. (1) Each health maintenance organization, limited service health organization and preferred provider plan shall do all of the following:

(a) Establish and use an internal grievance procedure that is approved by the commissioner and that complies with sub. (2) for the resolution of enrolled participants' grievances with the health care plan.

(b) Provide enrolled participants with complete and understandable information describing the internal grievance procedure under par. (a).

(c) Submit an annual report to the commissioner describing the internal grievance procedure under par. (a) and summarizing the experience under the procedure for the year.

(2) The internal grievance procedure established under sub. (1) (a) shall include all of the following elements:

(a) The opportunity for an enrolled participant to submit a written grievance in any form.

(b) Establishment of a grievance panel for the investigation of each grievance submitted under par. (a), consisting of at least one individual authorized to take corrective action on the grievance and at least one enrolled participant other than the grievant, if an enrolled participant is available to serve on the grievance panel.

(c) Prompt investigation of each grievance submitted under par. (a).

(d) Notification to each grievant of the disposition of his or her grievance and of any corrective action taken on the grievance.

(e) Retention of records pertaining to each grievance for at least 3 years after the date of notification under par. (d).

History: 1985 a. 29.

609.17 Reports of disciplinary action. Every health maintenance organization, limited service health organization and preferred provider 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 selected provider who holds a license or certificate granted by the board or affiliated credentialing board.

History: 1985 a. 340; 1993 a. 107.

609.20 Rules for preferred provider plans. The commissioner shall promulgate rules applicable to preferred provider plans for all of the following purposes:

(1) To ensure that enrolled participants are not forced to travel excessive distances to receive health care services.

(2) To ensure that the continuity of patient care for enrolled participants is not disrupted.

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

(4) To ensure that employes offered a preferred provider plan that provides comprehensive services under s. 609.10 (1) (a) are given adequate notice of the opportunity to enroll and complete and understandable information under s. 609.10 (1) (c) concerning the differences between the preferred provider plan and the standard plan, including differences between providers available and differences resulting from special limitations or requirements imposed by an institutional provider because of its affiliation with a religious organization.

History: 1985 a. 29.

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 enrolled participant of a health maintenance organization, limited service health organization or preferred provider plan is examined, evaluated or treated for a nervous or mental disorder pursuant to an emergency detention under s. 51.15, a commitment or a court order under s. 51.20 or 880.33 (4m) or (4r) or ch. 980, then, notwithstanding the limitations regarding selected providers, primary providers and referrals under ss. 609.01 (2) to (4) and 609.05 (3), the health maintenance organization, limited service health organization or preferred provider plan shall do all of the following:

(a) If the provider performing the examination, evaluation or treatment has a provider agreement with the health maintenance organization, limited service health organization or preferred provider plan which covers the provision of that service to the enrolled participant, make the service available to the enrolled

participant in accordance with the terms of the health care plan and the provider agreement.

(b) If the provider performing the examination, evaluation or treatment does not have a provider agreement with the health maintenance organization, limited service health organization or preferred provider plan which covers the provision of that service to the enrolled participant, reimburse the provider for the examination, evaluation or treatment of the enrolled participant 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 health maintenance organization, limited service health organization or preferred provider 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 health maintenance organization, limited service health organization or preferred provider plan within 72 hours after the initial provision of the service.

(2) If after receiving notice under sub. (1) (b) 2. the health maintenance organization, limited service health organization or preferred provider plan arranges for services to be provided by a provider with whom it has a provider agreement, the health maintenance organization, limited service health organization or preferred provider 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 health maintenance organization, limited service health organization or preferred provider plan is only required to make available, or make reimbursement for, an examination, evaluation or treatment under sub. (1) to the extent that the health maintenance organization, limited service health organization or preferred provider plan would have made the medically necessary service available to the enrolled participant 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 provider selected by the health maintenance organization, limited service health organization or preferred provider plan.

History: 1987 a. 366; 1993 a. 316, 479; 1995 a. 27.

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 health maintenance organization.

2. Is enrolled in a school located in this state but outside the geographical service area of the health maintenance organization.

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

(c) "School" means a technical college; a center or 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 health maintenance organization 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 health maintenance organization, notwithstanding the limitations regarding selected providers, primary providers and referrals under ss. 609.01 (2) and 609.05 (3).

(3) Except as provided in sub. (5), a health maintenance organization 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. or 3. 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 health maintenance organization.

(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 health maintenance organization, except as follows:

1. Coverage is not required under this paragraph if the medical director of the health maintenance organization 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 health maintenance organization 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 health maintenance organization 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 health maintenance organization's internal grievance procedure established under s. 609.15.

(5) (a) A policy or certificate issued by a health maintenance organization 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 selected provider within the geographical service area of the health maintenance organization.

(b) Paragraph (a) does not permit a health maintenance organization 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 selected provider within the geographical service area of the health maintenance organization.

History: 1989 a. 121; 1993 a. 399.

609.70 Chiropractic coverage. Health maintenance organizations, limited service health organizations and preferred provider plans are subject to s. 632.87 (3).

History: 1987 a. 27.

609.75 Adopted children coverage. Health maintenance organizations, limited service health organizations and preferred provider 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 health maintenance organization, limited service health organization or pre-

ferred provider plan imposes under s. 609.05 (2) and (3) on the coverage of health care services obtained by other enrolled participants.

History: 1989 a. 336.

609.80 Coverage of mammograms. Health maintenance organizations 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 health maintenance organization or preferred provider plan imposes under s. 609.05 (2) and (3) on the coverage of other health care services obtained by enrolled participants.

History: 1989 a. 129.

609.81 Coverage related to HIV infection. Health maintenance organizations, limited service health organizations and preferred provider plans are subject to s. 631.93. Health maintenance organizations and preferred provider plans are subject to s. 632.895 (9).

History: 1989 a. 201; 1989 a. 359 s. 389.

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

History: 1993 a. 450.

609.91 Restrictions on recovering health care costs. **(1)** IMMUNITY OF ENROLLED PARTICIPANTS AND POLICYHOLDERS. Except as provided in sub. (1m), an enrolled participant 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% 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 selected 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 selected 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 enrolled participant, policyholder or insured under a policy issued by an insurer to the department of health and family 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.

(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 enrolled participant, policyholder or insured, or any person acting on their behalf, for health care costs for which the enrolled participant, policyholder or insured, or person acting on their behalf, is not liable under sub. (1) or (1m).

(3) DEDUCTIBLES, COPAYMENTS AND PREMIUMS. Subsections (1) to (2) do not affect the liability of an enrolled participant, 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).

(4) CONDITIONS NOT AFFECTING THE IMMUNITY. The immunity of an enrolled participant, 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 any other person, at any time, whether oral or written and whether implied or explicit, including an agreement that purports to hold the enrolled participant, 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 any other person to compensate the provider, directly or indirectly, for health care costs, including health care costs for which the enrolled participant, policyholder or insured is not liable under sub. (1) or (1m).

(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 enrolled participant or policyholder is not liable under sub. (1).

(cm) The insolvency of the insurer described in sub. (1m) 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 enrolled participant, policyholder or insured is not liable under sub. (1m).

(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 any other person for health care costs for which the enrolled participant, policyholder or insured is not liable under sub. (1) or (1m).

(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).

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 selected 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 enrolled participant of that health maintenance organization insurer.

History: 1989 a. 23.

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 subsec-

tion 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 selected provider of the health maintenance organization insurer, at the time that the provider becomes a selected 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.

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% 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% 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% 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% 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%, 4.5% 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%, 3% 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%, 6% 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%, 3% 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 (3) (a) 1.

(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% 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% 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% 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) (a) or (b).

(b) To the extent that the amount on deposit exceeds 1% 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) (a) or (b).

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

History: 1989 a. 23.