Chapter Ins 9

APPENDIX A

AUDITOR'S SPECIAL PROCEDURES REPORT ON THE SCHEDULE OF COVERED EXPENSES

Board of Directors

XYZ Health Maintenance Organization Insurer

We have performed the following special procedures with respect to the Schedule of Covered Expenses for XYZ health maintenance organization insurer ("HMO insurer"), for the year ended December 31, XXXX. It is understood that this report is solely to assist you in complying with ch. Ins 9, Wis. Adm. Code, and ch. 609, Wis. Stats., and our report is not to be used for any other purpose. Our procedures and findings are as follows:

a. A randomly selected sample was taken from all medical and hospital expenses paid during the calendar year to test the attribute that the expenses reported on the provider's IRS 1099–MISC forms (or other supporting documentation for providers not issued an IRS–1099–MISC form) trace to the Schedule of Covered Expenses for those providers included on the Schedule of Covered Expenses.

b. A comparison was made between the Schedule of Covered Expenses and the Election of Exemption notices by providers to verify that providers which had given notice of their Election of Exemption prior to December 31, XXXX, and which had not also given notice of their Termination of Election prior to December 31, XXXX, are excluded from the Schedule of Covered Expenses.

A review of the assumptions and methods of the HMO insurer in establishing the amount of covered expenses included in the Incurred But Not Reported line of the Schedule of Covered Expenses was undertaken to determine if the company's estimate is reasonably estimated based on the HMO insurer's historical data and best information available to the HMO insurer.

Because the procedures do not constitute an examination made in accordance with generally accepted auditing standards, we do not express an opinion on any of the accounts or items referred to above. The following summarizes our findings as a result of the procedures referred to above.

FINDINGS REPORTED HERE

Had we performed any additional procedures, other matters might have come to our attention that would have been reported to you. This report relates only to the items specified above and does not extend to any financial statements of the HMO insurer taken as a whole.

_____ _____

Date CPA Signature

Chapter Ins 9

APPENDIX B

AUDITOR'S REPORT ON THE SCHEDULE OF COVERED EXPENSES

Date

BOARD OF DIRECTORS

XYZ Health Maintenance Organization Insurer

We have audited, in accordance with generally accepted auditing standards, Financial Statements of XYZ health maintenance organization insurer ("HMO insurer"), for the year ended December 31, XXXX, and have issued our report thereon dated XXXXXXXXXX XX, XXXX. We have also audited the accompanying Schedule of Covered Expenses for XYZ HMO insurer as of December 31, XXXX. This schedule is the responsibility of management of XYZ HMO insurer. Our responsibility is to express an opinion on this schedule based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the aforementioned schedule is free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the aforementioned schedule. An audit also includes assessing the accounting principles used and any significant estimates made by management, as well as evaluating the overall schedule presentations. We believe that our audit provides reasonable basis for our opinion.

In our opinion, the schedule referred to above presents fairly, in all material respects, covered expenses for the year ended December 31, XXXX.

_____ _____

Date CPA Signature

Chapter Ins 9

APPENDIX C

NOTICE
THIS NOTICE DESCRIBES HOLD–HARMLESS PROVISIONS WHICH AFFECT YOUR ABILITY TO SEEK RECOURSE AGAINST HEALTH MAINTENANCE ORGANIZATION INSURER ENROLLEES FOR PAYMENT FOR SERVICES

Section 609.94, Wis. Stat., requires each health maintenance organization insurer ("HMO insurer"), to provide a summary notice to all of its participating providers of the statutory limitations and requirements in §§ 609.91 to 609.935, and § 609.97 (1), Wis. Stats.

SUMMARY

Under Wisconsin law a health care provider may not hold HMO insurer enrollees or policyholders ("enrollees") liable for costs covered under an HMO insurer policy if the provider is subject to statutory provisions which "hold harmless" the enrollees. For most health care providers application of the statutory hold–harmless is "mandatory" or it applies unless the provider elects to "opt–out." A provider permitted to "opt–out" must file timely notice with the Wisconsin Office of the Commissioner of Insurance ("OCI").

Some types of provider care are subject to the hold–harmless statutes only if the provider voluntarily "opts–in." An HMO insurer may partially satisfy its regulatory capital and surplus requirements if health care providers elect to remain subject to the statutory hold–harmless provisions.

This notice is only a summary of the law. Every effort has been made to accurately describe the law. However, if this summary is inconsistent with a provision of the law or incomplete, the law will control.

Filings for exemption with OCI must be on the prescribed form in order to be effective.

HOLD HARMLESS

A health care provider who is subject to the statutory hold–harmless provisions is prohibited from seeking to recover health care costs from an enrollee. The provider may not bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency or have any recourse against an enrollee or any person acting on the enrollee's behalf, for health care costs for which the enrollee is not liable. The prohibition on recovery does not effect the liability of an enrollee for any deductibles or copayments, or for premiums owed under the policy or certificate issued by the HMO insurer.

A. MANDATORY FOR HOLD HARMLESS.

An enrollee of an HMO insurer is not liable to a health care provider for health care costs that are covered under a policy issued by that HMO insurer if any of the following are met:

1. Care is provided by a provider who is an affiliate of the HMO insurer, owns at least 5% of the voting securities of the HMO insurer, is directly or indirectly involved with the HMO insurer through direct or indirect selection of or representation by one or more board members, or is an Individual Practice Association ("IPA") and is represented, or an affiliate is represented, by one of at least three HMO insurer board members who directly or indirectly represent one or more IPAs or affiliates of IPAs.

2. Care is provided by a provider under a contract with or through membership in an organization identified in 1.

3. To the extent the charge exceeds the amount the HMO insurer has contractually agreed to pay the provider for that health care service.

4. The care is provided to an enrolled medical assistance recipient under a Department of Health and Family Services prepaid health care policy.

5. The care is required to be provided under the requirements of s. Ins 9.35, Wis. Adm. Code.

B. "OPT–OUT" HOLD HARMLESS.

If the conditions described in A do not apply, the provider will be subject to the statutory hold harmless unless the provider files timely election with OCI to be exempt if the health care meets any of the following:

1. Provided by a hospital or an IPA.

2. A physician service, or other provider services, equipment, supplies or drugs that are ancillary or incidental to such services and are provided under a contract with the HMO insurer or are provided by a provider selected by the HMO insurer.

3. Provided by a provider, other than a hospital, under a contract with or through membership in an IPA that has not elected to be exempt. Note that only the IPA may file election to exempt care provided by its member providers from the statutory hold harmless. (See Exemptions and Elections, No. 4.)

C. "OPT–IN" HOLD HARMLESS.

If a provider of health care is not subject to the conditions described in A or B, the provider may elect to be subject to the statutory hold–harmless provisions by filing a notification with OCI stating that the provider elects to be subject with respect to any specific HMO insurer. A provider may terminate such a notice of election by stating the termination date in that notice or in a separate notification.

CONDITIONS NOT AFFECTING IMMUNITY

An enrollee's immunity under the statutory hold harmless is not affected by any of the following:

1. Any agreement entered into by a provider, an HMO insurer, or any other person, whether oral or written, purporting to hold the enrollee liable for costs (except a notice of election or termination permitted under the statute).

2. A breach of or default on any agreement by the HMO insurer, an IPA, or any other person to compensate the provider for health care costs for which the enrollee is not liable.

3. The insolvency of the HMO insurer or any person contracting with the HMO insurer, or the commencement of insolvency, delinquency or bankruptcy proceedings involving the HMO insurer or other persons which would affect compensation for health care costs for which an enrollee is not liable under the statutory hold harmless.

4. The inability of the provider or other person who is owed compensation to obtain compensation for health care costs for which the enrollee is not liable.

5. Failure by the HMO insurer to provide notice to providers of the statutory hold–harmless provisions.

6. Any other conditions or agreement existing at any time.

EXEMPTIONS AND ELECTIONS

Hospitals, IPAs, and providers of physician services who may "opt–out" may elect to be exempt from the statutory hold harmless and prohibition on recovery of health care costs under the following conditions and with the following notifications:

1. If the hospital, IPA, or other provider has a written contract with the HMO insurer, the provider must within thirty (30) days after entering into that contract provide a notice to OCI of the provider's election to be exempt from the statutory hold–harmless and recovery limitations for care under the contract.

2. If the hospital, IPA, or other provider does not have a contract with an HMO insurer, the provider must notify OCI that it intends to be exempt with respect to a specific HMO insurer and must provide that notice for the period January 1, 1990, to December 21, 1990, at least sixty (60) day before the health care costs are incurred; and must provide that notice for health care costs incurred on and after January 1, 1991, at least 90 days in advance.

3. A provider who submits a notice of election to be exempt may terminate that election by stating a termination date in the notice or by submitting a separate termination notice to OCI.

4. The election by an IPA to be exempt from the statutory provisions, or the failure of an IPA to so elect, applies to costs of health care provided by any provider, other than a hospital, under contract with or through membership in the IPA. Such a provider, other than a hospital, may not exercise an election separately from the IPA. Similarly, an election by a clinic to be exempt from the statutory limitations and restrictions or the failure of the clinic to elect to be exempt applies to costs of health care provided by any provider through the clinic. An individual provider may not exercise an election to be exempt separate from the clinic.

5. The statutory hold–harmless "opt–out" provision applies to physician services only if the services are provided under a contract with the HMO insurer or if the physician is a selected provider for the HMO insurer, unless the services are provided by a physician for a hospital, IPA or clinic which is subject to the statutory hold–harmless "opt–out" provision.

NOTICES

All notices of election and termination must be in writing and in accordance with rules promulgated by the Commissioner of Insurance. All notices of election or termination filed with OCI are not affected by the renaming, reorganization, merger, consolidation or change in control of the provider, HMO insurer, or other person. However, OCI may promulgate rules requiring an informational filing if any of these events occur.

Notices to the Office of the Commissioner of Insurance must be written, on the prescribed form, and received at the Office's current address:

P. O. Box 7873, Madison, WI 53707–7873

HMO INSURER CAPITAL AND SECURITY SURPLUS

Each HMO insurer is required to meet minimum capital and surplus standard ("compulsory surplus requirements"). These standards are higher if the HMO insurer has fewer than 90% of its liabilities covered by the statutory hold–harmless. Specifically, beginning January 1, 1992, the compulsory surplus requirement shall be at least the greater of $750,000 or 6% of the premiums earned by the HMO insurer in the last 12 months if its covered liabilities are less than 90%, or 3% of the premiums earned by the HMO insurer in the last 12 months if its covered liabilities are 90% or more. In addition to capital and surplus, an HMO insurer must also maintain a security surplus in the amount set by the Commissioner of Insurance.

FINANCIAL INFORMATION

An HMO insurer is required to file financial statements with OCI. You may request financial statements from the HMO insurer. OCI also maintains files of HMO insurer financial statements that can be inspected by the public.