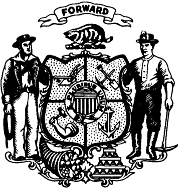

State of Wisconsin
1997 - 1998 LEGISLATURE

LRB-2407/1
PJK:kmg:jf

1997 SENATE BILL 218

May 27, 1997 – Introduced by Senators MOEN, WIRCH, DECKER, RISSER and CLAUSING, cosponsored by Representatives LORGE, MUSSER, DOBYNS, STASKUNAS, HANSON, WARD, R. YOUNG, GRONEMUS, AINSWORTH, ROBSON, MEYER, BAUMGART, PLOUFF, TRAVIS, MURAT, HASENOHRL and REYNOLDS. Referred to Committee on Health, Human Services, Aging, Corrections, Veterans and Military Affairs.

1 AN ACT ***to repeal*** 15.735 (1), 111.70 (4) (n), 185.983 (1g), 619.12 (2) (e) 2., 619.12
2 (2) (e) 3., 619.123, 632.70, 632.745, 632.747 (2), 632.749, subchapter I (title) of
3 chapter 635 [precedes 635.01], 635.01, 635.08 (1) (b), 635.18 (3) (c) and
4 subchapter II of chapter 635 [precedes 635.20]; ***to renumber*** 632.747 (3)
5 (intro.); ***to renumber and amend*** 619.12 (2) (e) 1., 632.747 (title), 632.747 (1),
6 632.747 (3) (a), 632.747 (3) (b), 632.747 (3) (c), 635.11, 635.15 and 635.18 (1); ***to***
7 ***amend*** 40.51 (8), 40.51 (8m), 60.23 (25), 66.184, 111.70 (1) (a), 111.91 (2) (k),
8 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 600.01 (2) (b), 625.12 (2), 628.34
9 (3) (a), 628.34 (3) (b), 628.36 (2) (b) 1., 628.36 (2) (b) 3., 628.36 (2) (b) 5., 631.01
10 (4), 632.76 (2) (a), 632.896 (4), 632.898 (7), chapter 635 (title), 635.11 (title),
11 635.13 (title), 635.13 (1), 635.18 (title), 635.18 (2), 635.18 (3) (a), 635.18 (3) (b),
12 635.18 (4), 635.18 (5), 635.18 (6), 635.18 (7) and 635.18 (8); ***to repeal and***
13 ***recreate*** 632.898 (1) (b), 635.02, 635.05 and 635.09; and ***to create*** 635.03,
14 635.06, 635.08, 635.11 (1m) (e), 635.11 (1m) (f), 635.11 (2m), 635.11 (3m),

1 635.16, 635.165 and 635.18 (1) (a) and (b) of the statutes; **relating to:** health
2 insurance coverage requirements, including preexisting condition exclusions,
3 guaranteed issue, guaranteed acceptance, portability, rating restrictions,
4 contract termination and renewability and fair marketing standards;
5 eliminating the small employer health insurance plan and board; collective
6 bargaining of certain health care coverage requirements; granting
7 rule–making authority; and requiring the exercise of rule–making authority.

Analysis by the Legislative Reference Bureau

GROUP HEALTH INSURANCE REQUIREMENTS UNDER CURRENT LAW

Current law contains a number of provisions that are known collectively as group health insurance market reform. The provisions went into effect on May 1, 1997, and apply to group health benefit plans that are sold to employers (including the state and municipalities) to provide health insurance coverage for their eligible employes (those that normally work 30 or more hours per week). Individual health benefit plans covering eligible employes of one employer are considered to be a group health benefit plan if 3 or more are sold to the employer. Most of the provisions also apply to self–insured health plans of the state and municipalities.

Guaranteed acceptance

An insurer that offers group health benefit plan coverage to any employer must offer coverage to all of the employer's eligible employes. Although such an insurer is not required to issue a group health benefit plan to any employer that applies for coverage, an insurer that does provide coverage to an employer group under a group health benefit plan must provide coverage under the plan to any employe who becomes eligible for coverage under the plan after the commencement of the employer's coverage. Additionally, such an insurer must provide coverage under the group health benefit plan to an eligible employe who waived coverage previously because he or she was covered as a dependent (usually as a spouse) under another health benefit plan, if the employe's coverage under the other health benefit plan was terminated not more than 30 days before the effective date of coverage under the group health benefit plan due to a divorce from the employe's spouse or due to the spouse's death or loss of coverage under the other health benefit plan.

Preexisting conditions and portability

A group health benefit plan may not exclude or limit benefits on account of a preexisting condition for more than 12 months after the commencement of an individual's coverage and may not define a preexisting condition more restrictively than a condition for which the individual sought or should have sought medical care during the 6 months immediately preceding the effective date of coverage.

Pregnancy may not be defined as a preexisting condition. A group health benefit plan must waive any period applicable to a preexisting condition exclusion or limitation for particular services for the period that the individual had other health insurance coverage that provided benefits with respect to those services and that terminated not more than 60 days before the effective date of coverage under the new plan.

Contract termination and renewability

A group health benefit plan may not be canceled before the expiration of the agreed term and must be renewed at the option of the policyholder, except for such reasons as failure to pay a premium when due or fraud or misrepresentation. An insurer may elect not to renew a group health benefit plan only if the insurer thereafter ceases to issue or renew any group health benefit plans for a minimum of 5 years.

CHANGES TO GROUP HEALTH INSURANCE REQUIREMENTS

This bill makes changes to current law, with respect to group health benefit plans, as a result of the passage by Congress of the Health Insurance Portability and Accountability Act of 1996. The bill also adds certain requirements for group health benefit plans that are unrelated to that act and other requirements that apply to individual health benefit plans. As under current law, most of the provisions also apply to self–insured health plans of the state and municipalities.

Guaranteed issue

With certain specified exceptions, an insurer that has in force a group health benefit plan must issue a group health benefit plan to any employer that agrees to pay the premiums and comply with all other plan provisions, and to all of the employer's eligible employes, without regard to health condition or claims experience. An insurer may be exempted from the requirement, however, for the remainder of a calendar year after the number of high–risk individuals covered by the insurer reaches a certain threshold level. The insurer must apply for exemption by certifying its qualification to the commissioner of insurance (commissioner), and, if the commissioner does not object, the insurer is exempted. The threshold level, as well as what constitutes a high–risk individual, is determined by the commissioner by rule, in consultation with a committee on risk adjustment. The commissioner appoints the 5 to 8 committee members, at least 5 of whom must be representatives of insurers.

Guaranteed acceptance and special enrollment periods

The bill does not change the requirement under current law that an insurer that issues a group health benefit plan must offer coverage under the plan to all of the employer's eligible employes. The bill requires such an insurer to cover an employe, or an employe's dependent, who is eligible for coverage under the plan and who did not enroll previously because he or she had other coverage. The insurer must enroll the employe or dependent if he or she still has the other coverage or if he or she requests enrollment within 30 days after the other coverage is exhausted or terminated. In addition, the bill requires an insurer offering coverage under a group health benefit plan to provide for special enrollment periods during which the spouse or newly born or adopted child of an enrollee under the plan may enroll under the

plan. Any such special enrollment period must begin within 30 days after the date of the marriage, birth or adoption, or within 30 days after the date on which dependent coverage is made available under the plan, whichever is later.

Preexisting conditions and portability

Under the bill, an insurer offering a group health benefit plan may impose a preexisting condition limitation or exclusion only if the limitation or exclusion relates to a condition for which the individual received medical advice or treatment within the 6–month period before the individual's enrollment date. The limitation or exclusion may extend no more than 12 months, or 18 months for a late enrollee (an individual who enrolls at a time other than the first period during which the individual is eligible to enroll or a special enrollment period). In addition, the length of time for which an insurer may impose a limitation or exclusion must be reduced by the aggregate of the individual's creditable coverage (defined in the bill to include many types of health care coverage), regardless of the benefits provided under the creditable coverage. A period of creditable coverage after which an individual had no coverage for at least 63 days is not counted toward the aggregate. Generally, beginning on October 1, 1996, an insurer is required to provide an individual with certification of creditable coverage when the individual's coverage under a health care plan provided by the insurer terminates.

An insurer may not treat genetic information as a preexisting condition without a diagnosis of a condition related to the information. An insurer may not impose a preexisting condition limitation or exclusion relating to pregnancy as a preexisting condition. An insurer may not impose any preexisting condition limitation or exclusion with respect to an individual if the individual had creditable coverage on the 30th day after the individual was born or adopted, unless the individual was without any creditable coverage for a period of at least 63 days.

Prohibiting discrimination

The bill prohibits an insurer from establishing rules for eligibility for group health benefit plan coverage on the basis of various specified factors, such as health status, claims experience, genetic information, disability or medical history. An insurer offering a group health benefit plan may not use any of the specified factors as a basis for charging an individual a higher premium than another similarly situated individual.

Contract termination and renewability

As under current law, an insurer that offers a group health benefit plan must renew the plan at the option of the employer unless certain specified events occur, such as the employer fails to pay premiums. The insurer may, however, discontinue offering a particular type of group health benefit plan if the insurer acts uniformly without regard to any health status–related factor of covered individuals and offers each affected employer the option to purchase another type of group health benefit plan that the insurer offers. The insurer may also discontinue offering in this state all group health benefit plans in the large group market (group health benefit plans sold to employers with more than 50 employes), in the market other than the large group market, or in both group markets, if the insurer does not issue any group health benefit plans in the affected market for 5 years.

Rate regulation

Under current law, the commissioner is required to promulgate rules that establish restrictions on premium rates and increases in premium rates that an insurer may charge for coverage provided to a small employer (one that employs not fewer than 2 nor more than 25 eligible employes). The restrictions must require that the rates charged by an insurer to small employers with employes with similar demographic, actuarially based characteristics for the same or similar benefit design characteristics not vary from the midpoint rate for those small employers by more than 35% of that midpoint rate. The bill expands the requirement for restrictions on rates to all group health benefit plans, regardless of the size of the employer group that the plan covers. The restrictions must require that the rates charged by an insurer to employers with employes with similar demographic, actuarially based characteristics for similar benefit design characteristics not vary from the midpoint rate for those employers by more than 30% of that midpoint rate. The restrictions for rate increases must allow for, among other things, an adjustment that does not exceed 15% per year for employers with 2 to 50 eligible employes or 25% per year for employers with more than 50 eligible employes.

INDIVIDUAL HEALTH INSURANCE REQUIREMENTS

The health insurance market reform provisions under current law apply only to group health benefit plans. This bill provides for similar health insurance market reform provisions for individual health benefit plans.

Guaranteed issue

With certain specified exceptions, an insurer that has in force an individual health benefit plan must issue an individual health benefit plan to an individual who is a resident of this state, without regard to health condition or claims experience. The individual must agree to pay the premium and comply with all other plan provisions and must have been covered, within 31 days before applying for the new coverage, under other health insurance that provided benefits similar to or exceeding the benefits under the new coverage. An insurer is exempt from the guaranteed issue requirement, for the remainder of a calendar year, if the insurer fulfills certain requirements set out in the bill based on the number of individuals covered by the insurer who fulfill the requirements necessary for guaranteed issue in comparison to the total number of individuals covered by the insurer under all individual health benefit plans.

Preexisting conditions, portability and other restrictions

Under the bill, an individual health benefit plan may not exclude or limit benefits on account of a preexisting condition for more than 12 months after the commencement of an individual's coverage and may not define a preexisting condition more restrictively than a condition for which the individual sought or should have sought medical care during the 18 months immediately preceding the effective date of coverage. An individual health benefit plan may not impose a preexisting condition limitation or exclusion relating to pregnancy as a preexisting condition. If the individual fulfills the requirements necessary for guaranteed issue of an individual health benefit plan, the plan must waive any period applicable to a

preexisting condition exclusion or limitation for particular services for the period that the individual was covered for those services under his or her previous health insurance coverage. In addition, the plan may not restrict the individual's coverage except to the extent that the individual's coverage was restricted under the previous health insurance coverage. The maximum lifetime benefits under the plan, however, may be reduced by the total benefits paid under the previous health insurance coverage.

Contract termination and renewability

Similar to the requirement for group health benefit plans, the bill requires an insurer to renew individual health benefit plan coverage at the option of the insured individual unless certain specified events occur, such as the individual fails to pay premiums. The insurer may, however, discontinue offering in this state a particular type of individual health benefit plan coverage if the insurer acts uniformly without regard to any health status–related factor of covered individuals and offers to each individual who has that type of coverage the option to purchase any other type of individual health benefit plan coverage that the insurer offers. The insurer may also discontinue offering in this state all individual health benefit plan coverage if the insurer does not issue in this state any individual health benefit plan coverage for 5 years.

Rate regulation

Similar to the requirement for group health benefit plans, the bill requires the commissioner to promulgate rules that establish restrictions on premium rates that an insurer may charge for coverage under an individual health benefit plan. The restrictions must require that the rates charged by an insurer to individuals with similar demographic, actuarially based characteristics for the same or similar benefit design characteristics not vary from the midpoint rate for those individuals by more than 35% of that midpoint rate. Unlike the requirement for group health benefit plans, the bill does not require the commissioner to establish restrictions on increases in premium rates for individual health benefit plans.

REPEAL OF BASIC BENEFITS PLAN

Under current law, a small employer may purchase a group health insurance policy providing basic benefits for the health insurance coverage of its employes. The small employer insurance board determines by rule most aspects of the basic benefits policies that insurers may offer to small employers, including the basic benefits that the policies must contain and the deductible, copayment and maximum benefit requirements for the policies. The bill eliminates the provisions related to the basic benefits policies, as well as the small employer insurance board.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

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

SECTION 1. 15.735 (1) of the statutes is repealed.

SECTION 2. 40.51 (8) of the statutes, as affected by 1995 Wisconsin Act 289, is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 632.72 (2), ~~632.745 (1) to (3) and (5), 632.747,~~ 632.87 (3) to (5), 632.895 (5m) and (8) to (10) and 632.896 and ch. 635.

SECTION 3. 40.51 (8m) of the statutes, as created by 1995 Wisconsin Act 289, is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ~~ss. 632.745 (1) to (3) and (5) and 632.747~~ ch. 635.

SECTION 4. 60.23 (25) of the statutes, as affected by 1995 Wisconsin Act 289, is amended to read:

60.23 **(25)** SELF–INSURED HEALTH PLANS. Provide health care benefits to its officers and employes on a self–insured basis if the self–insured plan complies with ss. 631.89, 631.90, 631.93 (2), ~~632.745 (2), (3) and (5) (a) 2. and (b) 2., 632.747 (3),~~ 632.87 (4) and (5), 632.895 (9) ~~and~~, 632.896, 635.03 and 635.04.

SECTION 5. 66.184 of the statutes, as affected by 1995 Wisconsin Act 289, is amended to read:

66.184 Self–insured health plans. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employes on a self–insured basis, the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), ~~632.745 (2), (3) and (5) (a) 2. and (b) 2., 632.747 (3),~~ 632.87 (4) and (5), 632.895 (9) and (10), 632.896, 635.03, 635.04, 767.25 (4m) (d) and 767.51 (3m) (d).

SECTION 6. 111.70 (1) (a) of the statutes, as affected by 1995 Wisconsin Act 289, is amended to read:

111.70 **(1)** (a) "Collective bargaining" means the performance of the mutual obligation of a municipal employer, through its officers and agents, and the representative of its municipal employes in a collective bargaining unit, to meet and confer at reasonable times, in good faith, with the intention of reaching an agreement, or to resolve questions arising under such an agreement, with respect to wages, hours and conditions of employment, and with respect to a requirement of the municipal employer for a municipal employe to perform law enforcement and fire fighting services under s. 61.66, except as provided in sub. (4) (m) and ~~(n) and~~ s. 40.81 (3) and except that a municipal employer shall not meet and confer with respect to any proposal to diminish or abridge the rights guaranteed to municipal employes under ch. 164. The duty to bargain, however, does not compel either party to agree to a proposal or require the making of a concession. Collective bargaining includes the reduction of any agreement reached to a written and signed document. The municipal employer shall not be required to bargain on subjects reserved to management and direction of the governmental unit except insofar as the manner of exercise of such functions affects the wages, hours and conditions of employment of the municipal employes in a collective bargaining unit. In creating this subchapter the legislature recognizes that the municipal employer must exercise its powers and responsibilities to act for the government and good order of the jurisdiction which it serves, its commercial benefit and the health, safety and welfare of the public to assure orderly operations and functions within its jurisdiction, subject to those rights secured to municipal employes by the constitutions of this state and of the United States and by this subchapter.

SECTION 7. 111.70 (4) (n) of the statutes, as created by 1995 Wisconsin Act 289, is repealed.

SECTION 8. 111.91 (2) (k) of the statutes, as created by 1995 Wisconsin Act 289, is amended to read:

111.91 **(2)** (k) Compliance with the health benefit plan requirements under ~~ss. 32.745 (1) to (3) and (5) and 632.747~~ ch. 635.

SECTION 9. 120.13 (2) (g) of the statutes, as affected by 1995 Wisconsin Act 289, is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), ~~632.745 (2), (3) and (5) (a) 2. and (b) 2., 632.747 (3),~~ 632.87 (4) and (5), 632.895 (9) and (10), 632.896, 635.03, 635.04, 767.25 (4m) (d) and 767.51 (3m) (d).

SECTION 10. 185.981 (4t) of the statutes, as affected by 1995 Wisconsin Act 289, is amended to read:

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.89, 632.72 (2), ~~632.745, 632.747, 632.749,~~ 632.87 (2m), (3), (4) and (5), 632.895 (10) and 632.897 (10) and ~~ch.~~ chs. 155 and 635.

SECTION 11. 185.983 (1) (intro.) of the statutes, as affected by 1995 Wisconsin Act 289, is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.89, 631.93, 632.72 (2), ~~632.745, 632.747, 632.749,~~ 632.775, 632.79, 632.795, 632.87 (2m), (3), (4) and (5), 632.895 (5), (9) and (10), 632.896 and 632.897 (10), subch. II of ch. 619 and chs. 609, 630, 635, 645 and 646, but the sponsoring association shall:

SECTION 12. 185.983 (1g) of the statutes is repealed.

SECTION 13. 600.01 (2) (b) of the statutes, as affected by 1995 Wisconsin Act 289, is amended to read:

600.01 **(2)** (b) Group or blanket insurance described in sub. (1) (b) 3. and 4. is not exempt from ~~s. 632.745, 632.747 or 632.749 or~~ ch. 633 or 635.

SECTION 14. 619.12 (2) (e) 1. of the statutes is renumbered 619.12 (2) (e) and amended to read:

619.12 **(2)** (e) ~~Except as provided in subd. 2., no~~ No person who is eligible for health care benefits, other than those benefits specified in s. 635.02 (14) (b) 1. to 14., that are provided by an employer on a self–insured basis or through health insurance is eligible for coverage under the plan.

SECTION 15. 619.12 (2) (e) 2. of the statutes is repealed.

SECTION 16. 619.12 (2) (e) 3. of the statutes is repealed.

SECTION 17. 619.123 of the statutes is repealed.

SECTION 18. 625.12 (2) of the statutes is amended to read:

625.12 **(2)** CLASSIFICATION. ~~Risks~~ Subject to s. 635.09, risks may be classified in any reasonable way for the establishment of rates and minimum premiums, except that no classifications may be based on race, color, creed or national origin, and classifications in automobile insurance may not be based on physical condition or developmental disability as defined in s. 51.01 (5). Subject to ~~s.~~ ss. 632.365 and 635.09, rates thus produced may be modified for individual risks in accordance with rating plans or schedules that establish reasonable standards for measuring probable variations in hazards, expenses, or both. Rates may also be modified for individual risks under s. 625.13 (2).

SECTION 19. 628.34 (3) (a) of the statutes, as affected by 1995 Wisconsin Act 289, is amended to read:

628.34 **(3)** (a) No insurer may unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage except on the basis of classifications related to the nature and the degree of the risk covered or the expenses involved, subject to ss. 632.365 ~~and 632.745~~, 635.03, 635.05, 635.08 and 635.09. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket or franchise policy, and terms are not unfairly discriminatory merely because they are more favorable than in a similar individual policy.

SECTION 20. 628.34 (3) (b) of the statutes, as affected by 1995 Wisconsin Act 289, is amended to read:

628.34 **(3)** (b) No insurer may refuse to insure or refuse to continue to insure, or limit the amount, extent or kind of coverage available to an individual, or charge an individual a different rate for the same coverage because of a mental or physical disability except when the refusal, limitation or rate differential is based on either sound actuarial principles supported by reliable data or actual or reasonably anticipated experience, subject to ss. ~~632.745, 632.747, 632.749, 635.09 and 635.26~~ 635.03 to 635.09, 635.16 and 635.165.

SECTION 21. 628.36 (2) (b) 1. of the statutes is amended to read:

628.36 **(2)** (b) 1. Except for health maintenance organizations, preferred provider plans~~,~~ and limited service health organizations ~~and the small employer health insurance plan under subch. II of ch. 635~~, no health care plan may prevent any person covered under the plan from choosing freely among providers who have

agreed to participate in the plan and abide by its terms, except by requiring the person covered to select primary providers to be used when reasonably possible.

SECTION 22. 628.36 (2) (b) 3. of the statutes is amended to read:

628.36 **(2)** (b) 3. Except as provided in subd. 4., no provider may be denied the opportunity to participate in a health care plan, other than a health maintenance organization, a limited service health organization~~,~~ or a preferred provider plan ~~or the small employer health insurance plan under subch. II of ch. 635~~, under the terms of the plan.

SECTION 23. 628.36 (2) (b) 5. of the statutes is amended to read:

628.36 **(2)** (b) 5. ~~Except for the small employer health insurance plan under subch. II of ch. 635 to the extent determined by the small employer insurance board under s. 635.23 (1) (b), all~~ All health care plans, including health maintenance organizations, limited service health organizations and preferred provider plans are subject to s. 632.87 (3).

SECTION 24. 631.01 (4) of the statutes is amended to read:

631.01 **(4)** ANNUITIES AND GROUP POLICIES FOR ELEEMOSYNARY INSTITUTIONS. This chapter~~,~~ and ch. 632 ~~and the health insurance mandates under ch. 632 that apply to the plan under subch. II of ch. 635~~ do not apply to annuities or group policies that are provided on a basis as uniform nationally as state statutes permit to educational, scientific research, religious or charitable institutions organized without profit to any person, for the benefit of employes of such institutions. The commissioner may by order subject such contracts issued by a particular insurer to this chapter~~,~~ or ch. 632 ~~or the health insurance mandates under ch. 632 that apply to the plan under subch. II of ch. 635~~ or any portion of those provisions upon a finding, after a hearing,

that the interests of Wisconsin insureds or creditors or the public of this state so require.

SECTION 25. 632.70 of the statutes is repealed.

SECTION 26. 632.745 of the statutes, as affected by 1995 Wisconsin Acts 289 and 453, is repealed.

SECTION 27. 632.747 (title) of the statutes, as created by 1995 Wisconsin Act 289, is renumbered 635.04 (title) and amended to read:

635.04 (title) **Guaranteed acceptance under group plans.**

SECTION 28. 632.747 (1) of the statutes, as created by 1995 Wisconsin Act 289, is renumbered 635.04 (1), and 635.04 (1) (intro.), as renumbered, is amended to read:

635.04 **(1)** EMPLOYE BECOMES ELIGIBLE AFTER COMMENCEMENT OF COVERAGE. (intro.) ~~If~~ Unless otherwise permitted by rule of the commissioner, if an insurer provides coverage under a group health benefit plan, the insurer shall provide coverage under the group health benefit plan to an eligible employe who becomes eligible for coverage after the commencement of the employer's coverage, and to the eligible employe's dependents, regardless of health condition or claims experience, if all of the following apply:

SECTION 29. 632.747 (2) of the statutes, as created by 1995 Wisconsin Act 289, is repealed.

SECTION 30. 632.747 (3) (intro.) of the statutes, as created by 1995 Wisconsin Act 289, is renumbered 635.04 (2) (intro.).

SECTION 31. 632.747 (3) (a) of the statutes, as created by 1995 Wisconsin Act 289, is renumbered 635.04 (2) (a) and amended to read:

635.04 **(2)** (a) The eligible employe was covered as a dependent under ~~qualifying~~ creditable coverage when he or she waived coverage under the self–insured health plan.

SECTION 32. 632.747 (3) (b) of the statutes, as created by 1995 Wisconsin Act 289, is renumbered 635.04 (2) (b) and amended to read:

635.04 **(2)** (b) The eligible employe's coverage under the ~~qualifying~~ creditable coverage has terminated or will terminate due to a divorce from the insured under the ~~qualifying~~ creditable coverage, the death of the insured under the ~~qualifying~~ creditable coverage, loss of employment by the insured under the ~~qualifying~~ creditable coverage or involuntary loss of coverage under the ~~qualifying~~ creditable coverage by the insured under the ~~qualifying~~ creditable coverage.

SECTION 33. 632.747 (3) (c) of the statutes, as created by 1995 Wisconsin Act 289, is renumbered 635.04 (2) (c) and amended to read:

635.04 **(2)** (c) The eligible employe applies for coverage under the self–insured health plan not more than 30 days after termination of his or her coverage under the ~~qualifying~~ creditable coverage.

SECTION 34. 632.749 of the statutes, as created by 1997 Wisconsin Act 289, is repealed.

SECTION 35. 632.76 (2) (a) of the statutes, as affected by 1995 Wisconsin Act 289, is amended to read:

632.76 **(2)** (a) No claim for loss incurred or disability commencing after 2 years from the date of issue of the policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of loss. This paragraph does not apply to a ~~group~~ health benefit

plan, as defined in s. ~~632.745 (1) (c)~~ 635.02 (14), which is subject to s. ~~632.745 (2)~~ 635.03 or 635.08 (2).

SECTION 36. 632.896 (4) of the statutes, as affected by 1995 Wisconsin Act 289, is amended to read:

632.896 **(4)** PREEXISTING CONDITIONS. Notwithstanding ss. ~~632.745 (2) and~~ 632.76 (2) (a), 635.03 and 635.08 (2), a disability insurance policy that is subject to sub. (2) and that is in effect when a court makes a final order granting adoption or when the child is placed for adoption may not exclude or limit coverage of a disease or physical condition of the child on the ground that the disease or physical condition existed before coverage is required to begin under sub. (3).

SECTION 37. 632.898 (1) (b) of the statutes is repealed and recreated to read:

632.898 **(1)** (b) "Dependent" means a spouse, an unmarried child under the age of 19 years, an unmarried child who is a full–time student under the age of 21 years and who is financially dependent upon the parent, or an unmarried child of any age who is medically certified as disabled and who is dependent upon the parent.

SECTION 38. 632.898 (7) of the statutes is amended to read:

632.898 **(7)** If the federal government enacts legislation providing for a federal income tax exemption for amounts deposited in an account established under this section and for any interest, dividends or other gain that accrues in the account if redeposited in the account, the commissioner shall conduct a study, to be completed within 4 years after the enactment of the federal legislation, of individuals and groups that had coverage under a high cost–share health plan and that terminated that coverage in order to enroll in a health benefit plan that was not a high cost–share health plan. If as a result of the study the commissioner determines that s. ~~632.745 (1) (f) 2.~~ 635.08 (1) (b) is not necessary for the purpose for which it was intended, the

commissioner shall certify that determination to the revisor of statutes. Upon the certification, the revisor of statutes shall publish notice in the Wisconsin administrative register of the determination, the date of the certification and that after 30 days after the date of the certification s. ~~632.745 (1) (f) 2.~~ 635.08 (1) (b) is not effective.

SECTION 39. Chapter 635 (title) of the statutes is amended to read:

CHAPTER 635

~~SMALL EMPLOYER~~ REGULATION

OF HEALTH INSURANCE

SECTION 40. Subchapter I (title) of chapter 635 [precedes 635.01] of the statutes is repealed.

SECTION 41. 635.01 of the statutes is repealed.

SECTION 42. 635.02 of the statutes, as affected by 1995 Wisconsin Act 289, is repealed and recreated to read:

635.02 Definitions. In this chapter, unless otherwise specified:

(1) "Affiliation period" means the period which, under the terms of health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective.

(2) "Base premium rate" means the lowest premium rate chargeable under a rating system to employers or individuals with similar case characteristics and the same or similar benefit design characteristics.

(3) "Beneficiary" has the meaning given in section 3 (8) of the federal Employee Retirement Income Security Act of 1974.

1 **(4)** "Benefit design characteristics" means covered services, cost sharing,
2 utilization management, managed care networks and other features that
3 differentiate plan or coverage designs.
4 **(5)** "Bona fide association" means an association that satisfies all of the
5 following:
6 (a) The association has been actively in existence for at least 5 years.
7 (b) The association has been formed and maintained in good faith for purposes
8 other than obtaining insurance.
9 (c) The association does not condition membership in the association on any
10 health status–related factor of an individual, including an employe of an employer
11 or a dependent of an employe.
12 (d) The association makes health insurance coverage offered through the
13 association available to all members, regardless of any health status–related factor
14 of those members or individuals eligible for coverage through a member.
15 (e) The association does not make health insurance coverage offered through
16 the association available other than in connection with a member of the association.
17 (f) The association meets any additional requirements that are imposed by a
18 rule of the commissioner designed to prevent the use of an association for risk
19 segmentation.
20 **(6)** "Case characteristics" means the age, gender, geographic location and
21 tobacco use of the individuals covered under a health benefit plan.
22 **(7)** (a) Except as provided in par. (b), "creditable coverage" means coverage
23 under any of the following:
24 1. A group health plan.
25 2. Health insurance.

1 3. Part A or part B of title XVIII of the federal Social Security Act.

2 4. Title XIX of the federal Social Security Act, except for coverage consisting
3 solely of benefits under section 1928 of that act.

4 5. Chapter 55 of title 10 of the United States Code.

5 6. A medical care program of the federal Indian health service or of an
6 American Indian tribal organization.

7 7. A state health benefits risk pool.

8 8. A health plan offered under chapter 89 of title 5 of the United States Code.

9 9. A public health plan, as defined in regulations issued by the federal
10 department of health and human services.

11 10. A health coverage plan under section 5 (e) of the federal Peace Corps Act,
12 22 USC 2504 (e).

13 (b) "Creditable coverage" does not include coverage consisting solely of
14 coverage of excepted benefits, as defined in section 2791 (c) of P.L. 104–191.

15 **(8)** (a) Except as provided in par. (b), "eligible employe" means an employe who
16 works on a permanent basis and has a normal work week of 30 or more hours. The
17 term includes a sole proprietor, a business owner, including the owner of a farm
18 business, a partner of a partnership and a member of a limited liability company if
19 the sole proprietor, business owner, partner or member is included as an employe
20 under a health benefit plan of an employer, but the term does not include an employe
21 who works on a temporary or substitute basis.

22 (b) For purposes of a group health benefit plan, or a self–insured health plan,
23 that is offered by the state under s. 40.51 (6) or by the group insurance board under
24 s. 40.51 (7), "eligible employe" has the meaning given in s. 40.02 (25).

25 **(9)** (a) "Employer" means any of the following:

1 1. An individual, firm, corporation, partnership, limited liability company or
2 association that is actively engaged in a business enterprise in this state, including
3 a farm business.
4 2. A municipality, as defined in s. 16.70 (8).
5 3. The state.
6 (b) For purposes of this definition, all of the following apply:
7 1. All persons treated as a single employer under subsection (b), (c), (m) or (o)
8 of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.
9 2. "Employer" includes any predecessor of an employer.
10 **(10)** "Enrollment date" means, with respect to an individual covered under a
11 group health plan, self–insured health plan or health insurance, the date of
12 enrollment of the individual under the plan or insurance or, if earlier, the first day
13 of the waiting period for such enrollment.
14 **(11)** "Federal continuation provision" means any of the following:
15 (a) Section 4980B of the Internal Revenue Code of 1986, except for section
16 4980B (f) (1) of that code insofar as it relates to pediatric vaccines.
17 (b) Part 6 of subtitle B of title I of the federal Employee Retirement Income
18 Security Act of 1974, except for section 609 of that act.
19 (c) Title XXII of P.L. 104–191.
20 **(12)** "Group health benefit plan" means a health benefit plan that is issued by
21 an insurer to or through an employer on behalf of a group consisting of at least 2
22 employes or a group including at least 2 eligible employes. The term includes
23 individual health benefit plans covering eligible employes when 3 or more are sold
24 to or through an employer.
25 **(13)** "Group health plan" means any of the following:

1 (a) An employe welfare plan, as defined in section 3 (1) of the federal Employee
2 Retirement Security Act of 1974, to the extent that the employe welfare plan provides
3 medical care, including items and services paid for as medical care, to employes or
4 to their dependents, as defined under the terms of the employe welfare plan, directly
5 or through insurance, reimbursement or otherwise.

6 (b) Any program that would not otherwise be an employe welfare benefit plan
7 and that is established or maintained by a partnership, to the extent that the
8 program provides medical care, including items and services paid for as medical care,
9 to present or former partners of the partnership or to their dependents, as defined
10 under the terms of the program, directly or through insurance, reimbursement or
11 otherwise.

12 **(14)** (a) Except as provided in par. (b), "health benefit plan" means any hospital
13 or medical policy or certificate.

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

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

17 2. Coverage issued as a supplement to liability insurance.

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

20 4. Worker's compensation or similar insurance.

21 5. Automobile medical payment insurance.

22 6. Credit–only insurance.

23 7. Coverage for on–site medical clinics.

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

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

10 10. Hospital indemnity or other fixed indemnity insurance or coverage only for
11 a specified disease or illness, if all of the following apply:

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

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

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

20 11. Benefits that are provided under a separate policy, certificate or contract
21 of insurance and that are medicare supplemental health insurance, as defined in
22 section 1882 (g) (1) of the federal Social Security Act, coverage supplemental to the
23 coverage provided under chapter 55 of title 10 of the United States Code or similar
24 supplemental coverage provided as supplemental to coverage under a group health
25 plan.

1 12. Short–term insurance.

2 13. Student–only medical plans.

3 14. Other insurance exempted by rule of the commissioner.

4 **(15)** "Health insurance" includes health benefit plans but does not include
5 group health plans.

6 **(16)** "Health maintenance organization" has the meaning given in s. 609.01 (2).

7 **(17)** "Health status–related factor" means any of the factors listed in s. 635.05
8 (1) (a).

9 **(18)** "Insurer" means an insurer that is authorized to do business in this state,
10 in one or more lines of insurance that includes health insurance, and that offers
11 health benefit plans covering individuals in this state or eligible employes of one or
12 more employers in this state. The term includes a health maintenance organization,
13 a preferred provider plan, as defined in s. 609.01 (4), an insurer operating as a
14 cooperative association organized under ss. 185.981 to 185.985 and a limited service
15 health organization, as defined in s. 609.01 (3).

16 **(19)** "Large employer" means, with respect to a calendar year and a plan year,
17 an employer that employed an average of at least 51 employes on business days
18 during the preceding calendar year, or that is reasonably expected to employ an
19 average of at least 51 employes on business days during the current calendar year
20 if the employer was not in existence during the preceding calendar year, and that
21 employs at least 2 employes on the first day of the plan year.

22 **(20)** "Large group market" means the health insurance market under which
23 individuals obtain health insurance coverage on behalf of themselves and their
24 dependents, directly or through any arrangement, under a group health benefit plan
25 maintained by a large employer.

1 **(21)** "Late enrollee" means, with respect to coverage under a group health plan,
2 a self-insured health plan or health insurance coverage, a participant, beneficiary
3 or individual who enrolls under the plan or coverage at any time other than during
4 any of the following:

5 (a) The first period in which the individual is eligible to enroll under the plan
6 or coverage.

7 (b) A special enrollment period under s. 635.03 (7).

8 **(22)** "Midpoint rate" means the arithmetic average of the base premium rate
9 and the corresponding highest premium rate.

10 (**23**) "Network plan" means health insurance coverage of an insurer under
11 which the financing and delivery of medical care, including items and services paid
12 for as medical care, are provided, in whole or in part, through a defined set of
13 providers under contract with the insurer.

14 **(24)** "New business premium rate" means the premium rate charged or offered
15 to employers or individuals with similar case characteristics for newly issued health
16 insurance with the same or similar benefit design characteristics.

17 **(25)** "Participant" has the meaning given in section 3 (7) of the federal
18 Employee Retirement Income Security Act of 1974. "Participant" includes an
19 individual who is, or may become, eligible to receive a benefit, or whose beneficiaries
20 may be eligible to receive any such benefit, in connection with a group health plan
21 or group health benefit plan if the individual is any of the following:

22 (a) A partner in relation to a partnership and the group health plan or group
23 health benefit plan is maintained by the partnership.

1 (b) A self–employed individual with one or more employes who are participants
2 in the group health plan or group health benefit plan and the group health plan or
3 group health benefit plan is maintained by the self–employed individual.

4 **(26)** "Placed for adoption" or "placement for adoption" means, with respect to
5 the placement for adoption of a child with a person, the assumption and retention by
6 the person of a legal obligation for the total or partial support of the child in
7 anticipation of the adoption of the child. A child's placement for adoption with a
8 person terminates upon the termination of the person's legal obligation for support.

9 **(27)** "Plan sponsor" has the meaning given in section 3 (16) (B) of the federal
10 Employee Retirement Income Security Act of 1974.

11 **(28)** "Preexisting condition exclusion" means, with respect to coverage, a
12 limitation or exclusion of benefits relating to a condition of an individual that existed
13 before the individual's date of enrollment for coverage.

14 **(29)** "Rating period" means the period, determined by an insurer, during which
15 a premium rate established by the insurer remains in effect.

16 **(30)** "Self–insured health plan" means a self–insured health plan of the state
17 or a county, city, village, town or school district.

18 **(31)** "Short–term insurance" means a temporary individual major medical or
19 accident insurance policy issued for a term of 6 months or less, except that such a
20 policy may be renewed one time at the expiration of the initial term for a term of 6
21 months or less.

22 **(32)** "Small employer" means, with respect to a calendar year and a plan year,
23 an employer that employed an average of at least 2 but not more than 50 employes
24 on business days during the preceding calendar year, or that is reasonably expected
25 to employ an average of at least 2 but not more than 50 employes on business days

1 during the current calendar year if the employer was not in existence during the
2 preceding calendar year, and that employs at least 2 employes on the first day of the
3 plan year.

4 **(33)** "Small group market" means the health insurance market under which
5 individuals obtain health insurance coverage on behalf of themselves and their
6 dependents, directly or through any arrangement, under a group health benefit plan
7 maintained by, or obtained through, a small employer.

8 **(34)** "Student–only medical plan" means a limited nonmedically underwritten
9 individual or group health benefit plan that is guaranteed renewable while the
10 covered person is enrolled as a regular, full–time undergraduate or graduate student
11 at an accredited technical or trade school, college or university and to which any of
12 the following applied at issuance:

13 (a) The student was not insured under a health benefit plan.

14 (b) The student was eligible for coverage under a health benefit plan of his or
15 her parent, stepparent or guardian but was unable to access the full health benefits
16 of the plan due to limitations in the plan's geographic service area.

17 **(35)** "Waiting period" means, with respect to a group health plan, a
18 self–insured health plan or health insurance coverage and an individual who is a
19 potential participant or beneficiary in the group health plan or self–insured health
20 plan or who is potentially covered by the health insurance coverage, the period that
21 must pass with respect to the individual before the individual is eligible for benefits
22 under the terms of the plan or coverage.

23 **SECTION 43.** 635.03 of the statutes is created to read:

24 **635.03 Preexisting conditions, portability, restrictions and special**
25 **enrollment periods for group plans.** **(1)** (a) Subject to subs. (2) and (3), a

1 self–insured health plan or an insurer that offers a group health benefit plan may,
2 with respect to a participant or beneficiary under the plan, impose a preexisting
3 condition exclusion only if the exclusion relates to a condition, whether physical or
4 mental, regardless of the cause of the condition, for which medical advice, diagnosis,
5 care or treatment was recommended or received within the 6–month period ending
6 on the participant's or beneficiary's enrollment date under the plan.

7 (b) A preexisting condition exclusion under par. (a) may not extend beyond 12
8 months, or 18 months with respect to a late enrollee, after the participant's or
9 beneficiary's enrollment date under the plan.

10 **(2)** (a) A self–insured health plan or an insurer offering a group health benefit
11 plan may not treat genetic information as a preexisting condition under sub. (1)
12 without a diagnosis of a condition related to the information.

13 (b) A self–insured health plan or an insurer offering a group health benefit plan
14 may not impose a preexisting condition exclusion relating to pregnancy as a
15 preexisting condition.

16 (c) Subject to par. (e), a self–insured health plan or an insurer offering a group
17 health benefit plan may not impose a preexisting condition exclusion with respect to
18 an individual who is covered under creditable coverage on the last day of the 30–day
19 period beginning with the day on which the individual is born.

20 (d) Subject to par. (e), a self–insured health plan or an insurer offering a group
21 health benefit plan may not impose a preexisting condition exclusion with respect to
22 an individual who is adopted or placed for adoption before attaining the age of 18
23 years and who is covered under creditable coverage on the last day of the 30–day
24 period beginning with the day on which the individual is adopted or placed for

1 adoption. This paragraph does not apply to coverage before the day on which the
2 individual is adopted or placed for adoption.

3 (e) Paragraphs (c) and (d) do not apply to an individual after the end of the first
4 continuous period during which the individual was not covered under any creditable
5 coverage for at least 63 days. For purposes of this paragraph, any waiting period or
6 affiliation period for coverage under a group health plan, group health benefit plan
7 or self–insured health plan shall not be taken into account in determining the period
8 before enrollment in the group health plan, group health benefit plan or self–insured
9 health plan.

10 **(3)** (a) The length of time during which any preexisting condition exclusion
11 under sub. (1) may be imposed shall be reduced by the aggregate of the participant's
12 or beneficiary's periods of creditable coverage on his or her enrollment date under the
13 group health benefit plan or self–insured health plan.

14 (b) With respect to enrollment of an individual under a group health plan,
15 group health benefit plan or self–insured health plan, a period of creditable coverage
16 after which the individual was not covered under any creditable coverage for a period
17 of at least 63 days before enrollment in the group health plan, group health benefit
18 plan or self–insured health plan may not be counted. For purposes of this paragraph,
19 any waiting period or affiliation period for coverage under the group health plan,
20 group health benefit plan or self–insured health plan shall not be taken into account
21 in determining the period before enrollment in the group health plan, group health
22 benefit plan or self–insured health plan.

23 (c) No period of creditable coverage before July 1, 1996, may be counted.
24 Individuals who need to establish creditable coverage for periods before July 1, 1996,
25 and who would have such coverage but for this paragraph may be given credit for

1 creditable coverage for such periods through the presentation of documents or other
2 means provided by the federal secretary of health and human services, consistent
3 with section 104 of P.L. 104–191.

4 (d) 1. A self–insured health plan or an insurer offering a group health benefit
5 plan shall count a period of creditable coverage without regard to the specific benefits
6 for which the individual had coverage during the period.

7 2. Notwithstanding subd. 1., an insurer offering a group health benefit plan
8 may elect to apply par. (a) on the basis of coverage of benefits within each of several
9 classes or categories of benefits specified in regulations issued by the federal
10 department of health and human services under P.L. 104–191. The election shall be
11 made on a uniform basis for all participants and beneficiaries. Under the election,
12 an insurer shall count a period of creditable coverage with respect to any class or
13 category of benefits if any level of benefits is covered within the class or category.

14 3. An insurer that makes an election under subd. 2. shall prominently state in
15 any disclosure statements concerning the coverage offered, and to each employer at
16 the time of the offer or sale of coverage, that the insurer has made the election and
17 what the effect of the election is.

18 (e) Periods of creditable coverage shall be established through the presentation
19 of certifications described in sub. (4) or in any other manner specified in regulations
20 issued by the federal department of health and human services under P.L. 104–191.

21 **(4)** (a) On and after October 1, 1996, an insurer that provides health benefit
22 plan coverage shall provide the certification described in par. (b) upon the happening
23 of any of the following events:

24 1. An individual ceases to be covered under the health benefit plan or otherwise
25 becomes covered under a federal continuation provision. The certification required

1 under this subdivision may be provided, to the extent practicable, at a time
2 consistent with notices required under any applicable federal continuation provision
3 or s. 632.897.
4 2. An individual ceases to be covered under a federal continuation provision.
5 3. Upon the request of an individual that is made not later than 24 months after
6 the date of the cessation of the individual's coverage under subd. 1. or 2., whichever
7 is later.
8 (b) The certification required under this subsection shall be a written
9 certification that includes all of the following information:
10 1. The period of creditable coverage of the individual under the health benefit
11 plan and the coverage, if any, under the federal continuation provision.
12 2. The waiting period, if any, or affiliation period, if any, imposed with respect
13 to the individual for coverage under the health benefit plan.
14 (c) Upon the happening after June 30, 1996, and before October 1, 1996, of an
15 event described in par. (a) 1. to 3., an insurer providing health benefit plan coverage
16 shall provide a certification described in par. (b) if the individual with respect to
17 whom the certification is provided requests the certification in writing.
18 (d) If an individual seeks to establish creditable coverage with respect to a
19 period for which a certification is not required because of the happening of an event
20 described in par. (a) 1. to 3. before July 1, 1996, all of the following apply:
21 1. The individual may present other credible evidence of the coverage in order
22 to establish the period of creditable coverage.
23 2. An insurer may not be subject to any penalty or enforcement action with
24 respect to the crediting or not crediting of the individual's coverage under subd. 1.

1 if the insurer has sought to comply in good faith with any applicable requirements
2 under this subsection.

3 **(5)** (a) If an insurer that made an election under sub. (3) (d) 2. enrolls an
4 individual for coverage under a group health benefit plan and the individual provides
5 a certification under sub. (4), upon the request of that insurer or the group health
6 benefit plan the insurer that issued the certification shall promptly disclose to the
7 requesting insurer or group health benefit plan information on coverage of classes
8 or categories of health benefits available under the coverage on which the
9 certification was based.

10 (b) The insurer providing the information may charge the requesting insurer
11 or plan for the reasonable cost of disclosing the information.

12 (c) An insurer providing information under this subsection shall comply with
13 regulations issued by the federal department of health and human services under
14 section 2701 (e) (3) of P.L. 104–191.

15 **(6)** A self–insured health plan or an insurer offering a group health benefit plan
16 shall permit an employe who is not enrolled but who is eligible for coverage under
17 the terms of the self–insured health plan or group health benefit plan, or a
18 participant's or employe's dependent who is not enrolled but who is eligible for
19 coverage under the terms of the self–insured health plan or group health benefit
20 plan, to enroll for coverage under the terms of the plan if all of the following apply:

21 (a) The employe or dependent was covered under a group health plan or
22 self–insured health plan or had health insurance coverage at the time coverage was
23 previously offered to the employe or dependent.

24 (b) The employe or participant stated in writing at the time coverage was
25 previously offered that coverage under a group health plan, self–insured health plan

1 or health insurance coverage was the reason for declining enrollment under the
2 self–insured health plan or insurer's group health benefit plan. This paragraph
3 applies only if the self–insured health plan or insurer required such a statement at
4 the time coverage was previously offered and provided the employe or participant,
5 at the time coverage was previously offered, with notice of the requirement and the
6 consequences of the requirement.

7 (c) The employe or dependent is currently covered under the group health plan,
8 self–insured health plan or health insurance or, under the terms of the self–insured
9 health plan or group health benefit plan, the employe or participant requests
10 enrollment no later than 30 days after the date on which the coverage under par. (a)
11 is exhausted or terminated.

12 **(7)** (a) If par. (b) applies, a self–insured health plan or an insurer offering a
13 group health benefit plan shall provide for a special enrollment period during which
14 any of the following may occur:

15 1. A person who marries an individual and who is otherwise eligible for
16 coverage may be enrolled under the plan as a dependent of the individual.

17 2. A person who is born to, adopted by or placed for adoption with, an individual
18 may be enrolled under the plan as a dependent of the individual.

19 3. An individual who has met any waiting period applicable to becoming a
20 participant under the plan, who is eligible to be enrolled under the plan and who
21 failed to enroll during a previous enrollment period or such an individual's spouse,
22 or both, may be enrolled under the plan.

23 (b) A self–insured health plan or an insurer under par. (a) is required to provide
24 for a special enrollment period if all of the following apply:

1 1. The self–insured health plan or group health benefit plan makes coverage
2 available for dependents of participants under the plan.
3 2. The individual is a participant under the plan, or the individual has met any
4 waiting period applicable to becoming a participant under the plan and is eligible to
5 be enrolled under the plan but failed to enroll during a previous enrollment period.
6 3. A person becomes a dependent of the individual through marriage, birth,
7 adoption or placement for adoption.
8 (c) A special enrollment period provided for under this subsection shall be for
9 a period of not less than 30 days and shall begin on the later of either of the following:
10 1. The date dependent coverage is made available under the self–insured
11 health plan or group health benefit plan.
12 2. The date of the marriage, birth, adoption or placement for adoption described
13 in par. (a), whichever is applicable.
14 (d) If an individual seeks to enroll a dependent during the first 30 days of a
15 special enrollment period, the coverage of the dependent shall become effective on
16 the following date:
17 1. If the person becomes a dependent through marriage, not later than the first
18 day of the first month beginning after the date on which the completed request for
19 enrollment is received.
20 2. If the person becomes a dependent through birth, as of the date of birth.
21 3. If the person becomes a dependent through adoption or placement for
22 adoption, the date of the adoption or placement for adoption.
23 **(8)** (a) A health maintenance organization that offers a group health benefit
24 plan and that does not impose any preexisting condition exclusion under sub. (1) with

1 respect to a particular coverage option may impose an affiliation period for that
2 coverage option, but only if all of the following apply:
3 1. The affiliation period is applied uniformly without regard to any health
4 status–related factors.
5 2. The affiliation period does not exceed 2 months, or 3 months with respect to
6 a late enrollee.
7 (b) A health maintenance organization that imposes an affiliation period under
8 this subsection is not required to provide health care services or benefits during the
9 affiliation period. A health maintenance organization may not charge a premium
10 to a participant or beneficiary for any coverage that is provided during an affiliation
11 period. An affiliation period shall begin on the enrollment date and run concurrently
12 with any waiting period under the group health benefit plan.
13 (c) A health maintenance organization under par. (a) may use methods other
14 than those described in par. (a) to address adverse selection, if the methods are
15 approved by the commissioner.
16 **(9)** (a) Except as provided in pars. (b) and (c), requirements used by an insurer
17 in determining whether to provide coverage under a group health benefit plan to an
18 employer, including requirements for minimum participation of eligible employes
19 and minimum employer contributions, shall be applied uniformly among all
20 employers that apply for or receive coverage from the insurer.
21 (b) An insurer may vary its minimum participation requirements and
22 minimum employer contribution requirements only by the size of the employer group
23 based on the number of eligible employes.
24 (c) An insurer may vary requirements used by the insurer in determining
25 whether to provide coverage under a group health benefit plan to a large employer,

1 but only if the requirements are applied uniformly among all large employers that
2 have the same number of eligible employes.

3 (d) In applying minimum participation requirements with respect to an
4 employer, an insurer may not count eligible employes who have other coverage that
5 is creditable coverage in determining whether the applicable percentage of
6 participation is met, except that an insurer may count eligible employes who have
7 coverage under another health benefit plan that is sponsored by that employer and
8 that is creditable coverage.

9 (e) An insurer may not increase a requirement for minimum employe
10 participation or a requirement for minimum employer contribution that applies to
11 an employer after the employer has been accepted for coverage.

12 (f) This subsection does not apply to a group health benefit plan offered by the
13 state under s. 40.51 (6) or by the group insurance board under s. 40.51 (7).

14 **(10)** (a) 1. Except as provided in rules promulgated under subd. 3., if an insurer
15 offers a group health benefit plan to an employer, the insurer shall offer coverage to
16 all of the eligible employes of the employer and their dependents. Except as provided
17 in rules promulgated under subd. 3., an insurer may not offer coverage to only certain
18 individuals in an employer group or to only part of the group, except for an eligible
19 employe who has not yet satisfied an applicable waiting period, if any.

20 2. Except as provided in rules promulgated under subd. 3., if the state or a
21 county, city, village, town or school district offers coverage under a self–insured
22 health plan, it shall offer coverage to all of its eligible employes and their dependents.
23 Except as provided in rules promulgated under subd. 3., the state or a county, city,
24 village, town or school district may not offer coverage to only certain individuals in

1 the employer group or to only part of the group, except for an eligible employe who
2 has not yet satisfied an applicable waiting period, if any.
3 3. The secretary of employe trust funds, with the approval of the group
4 insurance board, shall promulgate rules related to offering coverage to eligible
5 employes under a group health benefit plan, or a self–insured health plan, offered
6 by the state under s. 40.51 (6) or by the group insurance board under s. 40.51 (7). The
7 rules shall conform to the intent of subds. 1. and 2. and may not allow the state or
8 the group insurance board to refuse to offer coverage to an eligible employe or
9 dependent for reasons related to health condition.
10 (b) 1. An insurer may not modify a group health benefit plan with respect to
11 an employer or an eligible employe or dependent, through riders, endorsements or
12 otherwise, to restrict or exclude coverage for certain diseases or medical conditions
13 otherwise covered by the group health benefit plan.
14 2. The state or a county, city, village, town or school district may not modify a
15 self–insured health plan with respect to an eligible employe or dependent, through
16 riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases
17 or medical conditions otherwise covered by the self–insured health plan.
18 3. Nothing in this paragraph limits the authority of the group insurance board
19 to fulfill its obligations as trustee under s. 40.03 (6) (d) or to design or modify
20 procedures or provisions pertaining to enrollment, premium transmitted or coverage
21 of eligible employes for health care benefits under s. 40.51 (1).
22 **SECTION 44.** 635.05 of the statutes is repealed and recreated to read:
23 **635.05 Prohibiting discrimination under group health benefit plans.**
24 **(1)** (a) Subject to sub. (2), an insurer may not establish rules for the eligibility of any
25 individual to enroll, or for the continued eligibility of any individual to remain

1 enrolled, under a group health benefit plan based on any of the following factors with
2 respect to the individual or a dependent of the individual:
3 1. Health status.
4 2. Medical condition, including both physical and mental illnesses.
5 3. Claims experience.
6 4. Receipt of health care.
7 5. Medical history.
8 6. Genetic information.
9 7. Evidence of insurability, including conditions arising out of acts of domestic
10 violence.
11 8. Disability.
12 (b) For purposes of par. (a), rules for eligibility to enroll under a group health
13 benefit plan include rules defining any applicable waiting periods for enrollment.
14 **(2)** An insurer offering a group health benefit plan may not require any
15 individual, as a condition of enrollment or continued enrollment under the plan, to
16 pay, on the basis of any health status–related factor with respect to the individual
17 or a dependent of the individual, a premium or contribution that is greater than the
18 premium or contribution for a similarly situated individual enrolled under the plan.
19 **(3)** To the extent consistent with s. 635.03, sub. (1) shall not be construed to do
20 any of the following:
21 (a) Require a group health benefit plan to provide particular benefits other
22 than those provided under the terms of the plan.
23 (b) Prevent a group health benefit plan from establishing limitations or
24 restrictions on the amount, level, extent or nature of benefits or coverage for
25 similarly situated individuals enrolled under the plan.

1 **(4)** Nothing in sub. (1) shall be construed to do any of the following:

2 (a) Restrict the amount that an insurer may charge an employer for coverage
3 under a group health benefit plan.

4 (b) Prevent an insurer offering a group health benefit plan from establishing
5 premium discounts or rebates, or from modifying otherwise applicable copayments
6 or deductibles, in return for adherence to programs of health promotion and disease
7 prevention.

8 (c) Provide an exception from, or limit, the rate regulation under s. 635.09.

9 **SECTION 45.** 635.06 of the statutes is created to read:

10 **635.06 Guaranteed issue for group health benefit plans. (1)** Except as
11 provided in subs. (3) and (4), an insurer shall provide coverage under a group health
12 benefit plan to an employer and to all of the employer's eligible employes and their
13 dependents, regardless of health condition or claims experience, if all of the following
14 apply:

15 (a) The insurer has in force a group health benefit plan.

16 (b) The employer agrees to pay the premium required for coverage under the
17 group health benefit plan.

18 (c) The employer agrees to comply with all other provisions of the group health
19 benefit plan that apply generally to a policyholder or an insured without regard to
20 health condition or claims experience.

21 **(2)** An insurer that provides coverage under sub. (1) may impose payment
22 security provisions that are reasonably related to the risk covered.

23 **(3)** (a) An insurer that is otherwise required to provide coverage under sub. (1)
24 may refuse to issue a group health benefit plan to an employer if all of the individuals

1 in the employer group that are to be covered under the group health benefit plan may
2 be covered under one individual health benefit plan providing family coverage.

3 (b) Subsection (1) does not require an insurer to issue coverage that the insurer
4 is not authorized to issue under its bylaws, charter or certificate of incorporation or
5 authority.

6 (c) Subsection (1) does not require an insurer that provides coverage to an
7 employer under a group health benefit plan to issue a different group health benefit
8 plan to the employer before the expiration of the agreed term of the group health
9 benefit plan under which the employer has coverage.

10 (d) An insurer that offers health care coverage exclusively to a single category
11 or limited categories of employers may, with prior approval of the commissioner, limit
12 its compliance with sub. (1) to that single category or those limited categories of
13 employers.

14 (e) The commissioner may exempt an insurer from the requirements of sub. (1)
15 if the commissioner determines that it is in the public interest to exempt the insurer
16 from the requirements under sub. (1) because the insurer is in financially hazardous
17 condition.

18 (f) If an employer loses coverage under a group health benefit plan for failure
19 to pay a premium when due, an insurer that is otherwise required to provide
20 coverage under sub. (1) may refuse to issue a group health benefit plan to that
21 employer during the 12–month period beginning on the day on which the employer
22 lost coverage.

23 (g) An insurer that previously issued group health benefit plans but, prior to
24 the effective date of this paragraph .... [revisor inserts date], discontinued offering
25 such plans to small employers, shall within 60 days after the effective date of this

1 paragraph .... [revisor inserts date], again offer group health benefit plans to small
2 employers or be subject to the requirements under s. 635.16 as if the insurer had
3 elected to not renew a group health benefit plan.

4 **(4)** (a) In this subsection, "high–risk individual" means an individual with a
5 high–risk medical condition who has coverage under a group health benefit plan
6 with a premium rate at the insurer's highest premium rate level.

7 (b) An insurer that is otherwise required to provide coverage under sub. (1)
8 shall be exempt from the requirement under sub. (1) for the remainder of a calendar
9 year after all of the following occur:

10 1. The number of high–risk individuals covered by the insurer at least equals
11 the threshold level determined under par. (e) 3.

12 2. The insurer applies for exemption from the requirement under sub. (1) by
13 certifying its qualification under subd. 1. to the commissioner and the commissioner,
14 within 30 days after the insurer submits its certifying information, makes no
15 objection and does not request additional information. If the commissioner does
16 timely object or request additional information, the insurer shall be exempt from the
17 requirements under sub. (1) 30 days after the commissioner objects or the insurer
18 submits the additional information if the commissioner takes no further action.

19 (c) Whenever an insurer becomes exempt from the requirement under sub. (1)
20 by satisfying the criteria under par. (b), the commissioner shall provide notice of that
21 exemption to all insurers offering group health benefit plans to employers in this
22 state and to all insurance agents listed under s. 628.11 by those insurers.

23 (d) An insurer that satisfies the criterion under par. (b) 1. is not required to
24 apply for exemption from the requirement under sub. (1). An insurer that does not
25 apply for exemption shall remain subject to the requirement under sub. (1).

1 (e) In consultation with the committee on risk adjustment, the commissioner
2 shall promulgate rules for the operation of the risk adjustment mechanism under
3 this subsection, including rules that specify at least all of the following:
4 1. What diagnostic conditions constitute high risk medical conditions for
5 purposes of the definition of a high–risk individual.
6 2. How to determine an insurer's highest premium rate level for purposes of
7 the definition of a high–risk individual.
8 3. What percentage of an insurer's total enrollment under group health benefit
9 plans issued by the insurer constitutes the threshold level for purposes of par. (b) 1.
10 **SECTION 46.** 635.08 of the statutes is created to read:
11 **635.08 Coverage requirements for individual health benefit plans. (1)**
12 (a) In this section, "qualifying coverage" means benefits or coverage provided under
13 any of the following:
14 1. A group health benefit plan, group health plan or self–insured health plan
15 that provides benefits similar to or exceeding benefits provided under the health
16 benefit plan for which the individual is applying.
17 2. An individual health benefit plan that provides benefits similar to or
18 exceeding benefits provided under the health benefit plan for which the individual
19 is applying, if the individual health benefit plan has been in effect for at least one
20 year.
21 (b) Notwithstanding par. (a), "qualifying coverage" does not include a high
22 cost–share health plan, as defined in s. 632.898 (1) (c), that is linked to a medical
23 savings account, as described in s. 632.898, if the employer that provides the
24 individual's new coverage offers its eligible employes a choice of health benefit plan

1 options that includes a high cost–share health plan, as defined in s. 632.898 (1) (c),
2 and the individual's new coverage is not a high cost–share health plan.

3 **(2)** (a) An individual health benefit plan may not impose a preexisting
4 condition exclusion with respect to a covered individual for losses incurred more than
5 12 months after the individual's enrollment date under the plan.

6 (b) An individual health benefit plan may not define a preexisting condition
7 more restrictively than any of the following:

8 1. A condition that would have caused an ordinarily prudent person to seek
9 medical advice, diagnosis, care or treatment during the 18 months immediately
10 preceding the individual's enrollment date under the plan and for which the
11 individual did not seek medical advice, diagnosis, care or treatment.

12 2. A condition for which medical advice, diagnosis, care or treatment was
13 recommended or received during the 18 months immediately preceding the
14 individual's enrollment date under the plan.

15 (c) Notwithstanding pars. (a) and (b), an individual health benefit plan may not
16 impose a preexisting condition exclusion relating to pregnancy as a preexisting
17 condition.

18 **(3)** (a) Except as provided in pars. (b) and (g), an insurer shall provide coverage
19 under an individual health benefit plan to an individual who is a resident of this
20 state, regardless of health condition or claims experience, if all of the following apply:

21 1. The insurer has in force an individual health benefit plan.

22 2. The individual agrees to pay the premium required for coverage under the
23 individual health benefit plan.

3. The individual agrees to comply with all other provisions of the individual health benefit plan that apply generally to a policyholder or an insured without regard to health condition or claims experience.

4. The individual was covered under qualifying coverage that terminated not more than 31 days before the individual applied for the new coverage.

5. If the individual's qualifying coverage under subd. 4. was coverage under sub. (1) (a) 1., the individual had been covered under continuation coverage, as defined in s. 252.16 (1) (a), for the maximum allowable period; the individual is not now eligible for coverage under any group health benefit plan, group health plan or self–insured health plan; and the individual was an eligible employe for at least 6 months immediately before applying for the new coverage.

(b) 1. Paragraph (a) does not require an insurer to issue coverage that the insurer is not authorized to issue under its bylaws, charter or certificate of incorporation or authority.

2. Paragraph (a) does not require an insurer that provides coverage to an individual under an individual health benefit plan to issue a different individual health benefit plan to the individual before the expiration of the agreed term of the individual health benefit plan under which the individual has coverage.

3. An insurer that offers health care coverage exclusively to a single category or limited categories of individuals may, with prior approval of the commissioner, limit its compliance with par. (a) to the single category or those limited categories of individuals.

4. The commissioner may exempt an insurer from the requirement under par. (a) if the commissioner determines that it is in the public interest to exempt the

1 insurer from the requirement under par. (a) because the insurer is in financially
2 hazardous condition.

3 (c) An insurer that issues an individual health benefit plan to an individual
4 described in par. (a) shall provide coverage under the individual health benefit plan
5 for any dependents of the individual who had coverage under the individual's
6 qualifying coverage under par. (a) 4.

7 (d) An individual health benefit plan that is issued to an individual described
8 in par. (a) may not restrict or modify coverage with respect to the individual except
9 to the extent that the individual's qualifying coverage under par. (a) 4. was restricted
10 or modified.

11 (e) The maximum lifetime benefits available under an individual health benefit
12 plan that is issued to an individual described in par. (a) may be reduced by the total
13 benefits paid under the individual's qualifying coverage under par. (a) 4.

14 (f) An individual health benefit plan that is issued to an individual described
15 in par. (a) shall waive any period applicable to a preexisting condition exclusion
16 period with respect to particular services for the period that the individual was
17 covered with respect to such services under the individual's qualifying coverage
18 under par. (a) 4.

19 (g) An insurer that is otherwise required to provide coverage under par. (a)
20 shall be exempt from the requirement under par. (a) for the remainder of a calendar
21 year after all of the following occur:

22 1. The total number of individuals described under par. (a) and their
23 dependents who are covered by the insurer equals at least 1% of the total number of
24 individuals and their dependents covered under all individual health benefit plans

1 issued by the insurer that were in effect on December 31 of the preceding year and
2 that were qualifying coverage under sub. (1) (a) 2.
3 2. The insurer applies for exemption from the requirement under par. (a) by
4 submitting to the commissioner certification that includes all of the following:
5 a. The total number of individuals and their dependents covered under all
6 individual health benefit plans issued by the insurer that were in effect on December
7 31 of the preceding year and that were qualifying coverage under sub. (1) (a) 2.
8 b. The total number of individuals described under par. (a) and their
9 dependents who have been accepted by the insurer for coverage under par. (a) during
10 the current year.
11 (h) Whenever an insurer becomes exempt from the requirement under par. (a)
12 by satisfying the criteria under par. (g), the commissioner shall provide notice of that
13 exemption to all insurers offering individual health benefit plans to individuals in
14 this state and to all insurance agents listed under s. 628.11 by those insurers.
15 **SECTION 47.** 635.08 (1) (b) of the statutes, as created by 1997 Wisconsin Act ....
16 (this act), is repealed.
17 **SECTION 48.** 635.09 of the statutes is repealed and recreated to read:
18 **635.09 Rate regulation for individual and group health benefit plans.**
19 Notwithstanding ch. 625, the commissioner shall promulgate rules that do all of the
20 following:
21 **(1)** Establish restrictions on premium rates that an insurer may charge an
22 employer for coverage under a group health benefit plan such that the premium rates
23 charged to employers with similar case characteristics for the same or similar benefit
24 design characteristics do not vary from the midpoint rate for those employers by
25 more than 30% of that midpoint rate.

1 **(2)** Establish restrictions on premium rates that an insurer may charge an
2 individual for coverage under an individual health benefit plan such that the
3 premium rates charged to individuals with similar case characteristics for the same
4 or similar benefit design characteristics do not vary from the midpoint rate for those
5 individuals by more than 35% of that midpoint rate.

6 **(3)** Establish restrictions on increases in premium rates that an insurer may
7 charge an employer for coverage under a group health benefit plan such that:

8 (a) The percentage increase in the premium rate for a new rating period does
9 not exceed the sum of the following:

10 1. The percentage change in the new business premium rate measured from
11 the first day of the prior rating period to the first day of the new rating period.

12 2. An adjustment, not to exceed 15% per year for small employers or 25% per
13 year for large employers, adjusted proportionally for rating periods of less than one
14 year, for such rating factors as claims experience, health condition and duration of
15 coverage, determined in accordance with the insurer's rate manual or rating
16 procedures.

17 3. An adjustment for a change in case characteristics or in benefit design
18 characteristics, determined in accordance with the insurer's rate manual or rating
19 procedures.

20 (b) The percentage increase in the premium rate for a new rating period for a
21 group health benefit plan issued before the effective date of this paragraph ....
22 [revisor inserts date], does not exceed the sum of par. (a) 1. and 3., unless premium
23 rates are in compliance with the rules promulgated under sub. (1).

24 **(4)** Require the premium rate of a health benefit plan issued before the effective
25 date of this subsection .... [revisor inserts date], to comply with the rules promulgated

under sub. (1) or (2) no later than 2 years after the effective date of this subsection .... [revisor inserts date].

(5) Define the terms necessary for compliance with this section.

(6) Ensure that employers are classified using objective criteria.

(7) Ensure that rating factors are applied objectively and consistently to small employers.

SECTION 49. 635.11 (title) of the statutes is amended to read:

635.11 (title) **Disclosure of rating factors and renewability provisions for group health benefit plans.**

SECTION 50. 635.11 of the statutes is renumbered 635.11 (1m), and 635.11 (1m) (intro.), (a) and (d), as renumbered, are amended to read:

635.11 **(1m)** (intro.) Before the sale of a group health benefit plan ~~or policy subject to this subchapter, a small employer~~, an insurer shall disclose to ~~a small~~ an employer all of the following:

(a) The ~~small employer~~ insurer's right to increase premium rates and the factors limiting the amount of increase.

(d) The ~~small~~ employer's renewability rights.

SECTION 51. 635.11 (1m) (e) of the statutes is created to read:

635.11 **(1m)** (e) As part of the insurer's solicitation and sales materials, the availability of the information under par. (f).

SECTION 52. 635.11 (1m) (f) of the statutes is created to read:

635.11 **(1m)** (f) Upon the request of the employer, the following information:

1. The provisions, if any, of the plan or policy relating to preexisting condition exclusions.

2. The benefits and premiums available under all health insurance coverage offered by the insurer for which the employer is qualified.

SECTION 53. 635.11 (2m) of the statutes is created to read:

635.11 **(2m)** Information required to be disclosed under this section shall be provided in a manner that is understandable to an employer and shall be sufficient to reasonably inform an employer of the employer's rights and obligations under the health insurance coverage.

SECTION 54. 635.11 (3m) of the statutes is created to read:

635.11 **(3m)** An insurer is not required under this section to disclose information that is proprietary or trade secret information under applicable law.

SECTION 55. 635.13 (title) of the statutes is amended to read:

635.13 (title) **Annual certification of compliance for group health benefit plans.**

SECTION 56. 635.13 (1) of the statutes is amended to read:

635.13 **(1)** RECORDS. ~~A small employer~~ An insurer that issues group health benefit plans shall maintain at its principal place of business complete and detailed records with respect to those group health benefit plans relating to its rating methods and practices and its renewal underwriting methods and practices, and shall make the records available to the commissioner ~~and the small employer insurance board~~ upon request.

(2) CERTIFICATION. ~~A small employer~~ An insurer that issues group health benefit plans shall file with the commissioner on or before May 1 annually an actuarial opinion by a member of the American ~~academy of actuaries~~ Academy of Actuaries certifying all of the following with respect to those group health benefit plans:

(a) That the ~~small employer~~ insurer is in compliance with the rate provisions of s. ~~635.05~~ 635.09.

(b) That the ~~small employer~~ insurer's rating methods are based on generally accepted and sound actuarial principles, policies and procedures.

(c) That the opinion is based on the actuary's examination of the ~~small employer~~ insurer's records and a review of the ~~small employer~~ insurer's actuarial assumptions and statistical methods used in setting rates and procedures used in implementing rating plans.

SECTION 57. 635.15 of the statutes is renumbered 635.10 and amended to read:

635.10 (title) **Temporary suspension of rate regulation for individual and group health benefit plans.** The commissioner may suspend the operation of all or any part of s. ~~635.05~~ 635.09 with respect to one or more ~~small~~ employers or one or more individuals for one or more rating periods upon the written request of ~~a small employer~~ an insurer and a finding by the commissioner that the suspension is necessary in light of the financial condition of the ~~small employer~~ insurer or that the suspension would enhance the efficiency and fairness of the ~~small employer~~ health insurance market.

SECTION 58. 635.16 of the statutes is created to read:

635.16 Contract termination and renewability for group health benefit plans. (1) (a) Except as provided in subs. (2) to (4) and notwithstanding s. 631.36 (2) to (4m), an insurer that offers a group health benefit plan shall renew such coverage or continue such coverage in force at the option of the employer and, if applicable, plan sponsor.

(b) At the time of coverage renewal, the insurer may modify a group health benefit plan issued in the large group market.

1 **(2)** Notwithstanding s. 631.36 (2) to (4m), an insurer may nonrenew or
2 discontinue a group health benefit plan, but only if any of the following applies:
3 (a) The plan sponsor has failed to pay premiums or contributions in accordance
4 with the terms of the group health benefit plan or in a timely manner.
5 (b) The plan sponsor has performed an act or engaged in a practice that
6 constitutes fraud or made an intentional misrepresentation of material fact under
7 the terms of the coverage.
8 (c) The plan sponsor has failed to comply with a material plan provision that
9 is permitted under law relating to employer contribution or group participation
10 rules.
11 (d) The insurer is ceasing to offer coverage in the market in which the group
12 health benefit plan is included in accordance with sub. (3) and any other applicable
13 state law.
14 (e) In the case of a group health benefit plan that the insurer offers through a
15 network plan, there is no longer an enrollee under the plan who resides, lives or
16 works in the service area of the insurer or in an area in which the insurer is
17 authorized to do business.
18 (f) In the case of a group health benefit plan that is made available only through
19 one or more bona fide associations, the employer ceases to be a member of the
20 association on which the coverage is based. Coverage may be terminated if this
21 paragraph applies only if the coverage is terminated uniformly without regard to any
22 health status–related factor of any covered individual.
23 **(3)** (a) Notwithstanding s. 631.36 (2) to (4m), an insurer may discontinue
24 offering in this state a particular type of group health benefit plan offered in either

1 the large group market or the group market other than the large group market, but
2 only if all of the following apply:
3 1. The insurer provides notice of the discontinuance to each employer and, if
4 applicable, plan sponsor for whom the insurer provides coverage of this type in this
5 state, and to the participants and beneficiaries covered under the coverage, at least
6 90 days before the date on which the coverage will be discontinued.
7 2. The insurer offers to each employer and, if applicable, plan sponsor for whom
8 the insurer provides coverage of this type in this state the option to purchase from
9 among all of the other group health benefit plans that the insurer offers in the market
10 in which is included the type of group health benefit plan that is being discontinued,
11 except that in the case of the large group market, the insurer must offer each
12 employer and, if applicable, plan sponsor the option to purchase one other group
13 health benefit plan that the insurer offers in the large group market.
14 3. In exercising the option to discontinue coverage of this particular type and
15 in offering the option to purchase coverage under subd. 2., the insurer acts uniformly
16 without regard to any health status–related factor of any covered participants or
17 beneficiaries or any participants or beneficiaries who may become eligible for
18 coverage.
19 (b) Notwithstanding s. 631.36 (2) to (4m), an insurer may discontinue offering
20 in this state all group health benefit plans in the large group market or in the group
21 market other than the large group market, or in both such group markets, but only
22 if all of the following apply:
23 1. The insurer provides notice of the discontinuance to the commissioner and
24 to each employer and, if applicable, plan sponsor for whom the insurer provides
25 coverage of this type in this state, and to the participants and beneficiaries covered

under the coverage, at least 180 days before the date on which the coverage will be discontinued.

2. All group health benefit plans issued or delivered for issuance in this state in the affected market or markets are discontinued and coverage under such group health benefit plans is not renewed.

3. The insurer does not issue or deliver for issuance in this state any group health benefit plan in the affected market or markets before 5 years after the day on which the last group health benefit plan is discontinued under subd. 2.

(4) This section does not apply to a group health benefit plan offered by the state under s. 40.51 (6) or by the group insurance board under s. 40.51 (7).

SECTION 59. 635.165 of the statutes is created to read:

635.165 Guaranteed renewability of individual health benefit plans. **(1)** (a) Except as provided in subs. (2) and (3) and notwithstanding s. 631.36 (2) to (4m), an insurer that provides individual health benefit plan coverage shall renew such coverage or continue such coverage in force at the option of the insured individual and, if applicable, the association through which the individual has coverage.

(b) At the time of coverage renewal, the insurer may modify the individual health benefit plan coverage policy form as long as the modification is consistent with state law and effective on a uniform basis among all individuals with coverage under that policy form.

(2) Notwithstanding s. 631.36 (2) to (4m), an insurer may nonrenew or discontinue the individual health benefit plan coverage of an individual, but only if any of the following applies:

1 (a) The individual or, if applicable, the association through which the
2 individual has coverage has failed to pay premiums or contributions in accordance
3 with the terms of the health insurance coverage or in a timely manner.
4 (b) The individual or, if applicable, the association through which the
5 individual has coverage has performed an act or engaged in a practice that
6 constitutes fraud or made an intentional misrepresentation of material fact under
7 the terms of the health insurance coverage.
8 (c) The insurer is ceasing to offer individual health benefit plan coverage in
9 accordance with sub. (3) and any other applicable state law.
10 (d) In the case of individual health benefit plan coverage that the insurer offers
11 through a network plan, the individual no longer resides, lives or works in the service
12 area or in an area in which the insurer is authorized to do business. Coverage may
13 be terminated if this paragraph applies only if the coverage is terminated uniformly
14 without regard to any health status–related factor of covered individuals.
15 (e) In the case of individual health benefit plan coverage that the insurer offers
16 only through one or more bona fide associations, the individual ceases to be a member
17 of the association on which the coverage is based. Coverage may be terminated if this
18 paragraph applies only if the coverage is terminated uniformly without regard to any
19 health status–related factor of covered individuals.
20 (f) The individual is eligible for medicare and the commissioner by rule permits
21 coverage to be terminated.
22 **(3)** (a) Notwithstanding s. 631.36 (2) to (4m), an insurer may discontinue
23 offering in this state a particular type of individual health benefit plan coverage, but
24 only if all of the following apply:

1. The insurer provides notice of the discontinuance to each individual for whom the insurer provides coverage of this type in this state and, if applicable, to the association through which the individual has coverage at least 90 days before the date on which the coverage will be discontinued.

2. The insurer offers to each individual for whom the insurer provides coverage of this type in this state and, if applicable, to the association through which the individual has coverage the option to purchase any other type of individual health insurance coverage that the insurer offers for individuals.

3. In electing to discontinue coverage of this particular type and in offering the option to purchase coverage under subd. 2., the insurer acts uniformly without regard to any health status–related factor of enrolled individuals or individuals who may become eligible for the type of coverage described under subd. 2.

(b) Notwithstanding s. 631.36 (2) to (4m), an insurer may discontinue offering individual health benefit plan coverage in this state, but only if all of the following apply:

1. The insurer provides notice of the discontinuance to the commissioner and to each individual for whom the insurer provides individual health benefit plan coverage in this state and, if applicable, to the association through which the individual has coverage at least 90 days before the date on which the coverage will be discontinued.

2. All individual health benefit plan coverage issued or delivered for issuance in this state is discontinued and coverage under such coverage is not renewed.

3. The insurer does not issue or deliver for issuance in this state any individual health benefit plan coverage before 5 years after the day on which the last individual health benefit plan coverage is discontinued under subd. 2.

SECTION 60. 635.18 (title) of the statutes is amended to read:

635.18 (title) **Fair marketing standards for group and individual health benefit plans.**

SECTION 61. 635.18 (1) of the statutes is renumbered 635.18 (1) (intro.) and amended to read:

635.18 **(1)** (intro.) Every ~~small employer~~ insurer that provides coverage under a health benefit plan shall actively market such health benefit plan coverage~~, including basic health benefit plans, to small employers in the state. If a small employer insurer denies coverage to a small employer under a health benefit plan that is not a basic health benefit plan on the basis of the health status or claims experience of the small employer or its eligible employes or their dependents, the small employer insurer shall offer the small employer the opportunity to purchase a basic health benefit plan~~. In addition to other marketing limitations that the commissioner may authorize by rule, an insurer may limit its marketing under this subsection to any of the following:

SECTION 62. 635.18 (1) (a) and (b) of the statutes are created to read:

635.18 **(1)** (a) Health benefit plans for employer groups of all sizes.

(b) Health benefit plans for individuals.

SECTION 63. 635.18 (2) of the statutes is amended to read:

635.18 **(2)** (a) Except as provided in par. (b), ~~a small employer~~ an insurer or an intermediary may not, directly or indirectly, do any of the following:

1. Discourage ~~a small~~ an employer or an individual from applying, or direct ~~a small~~ an employer or an individual not to apply, for coverage with the ~~small employer~~ insurer because of the health ~~status~~ condition, claims experience, industry, occupation or geographic ~~location~~ area of the ~~small~~ employer or individual.

2. Encourage or direct ~~a small~~ an employer or an individual to seek coverage from another insurer because of the health ~~status~~ condition, claims experience, industry, occupation or geographic ~~location~~ area of the ~~small~~ employer or individual.

(b) Paragraph (a) does not prohibit ~~a small employer~~ an insurer or an intermediary from providing ~~a small~~ an employer or an individual with information about an established geographic service area or a restricted network provision of the ~~small employer~~ insurer.

SECTION 64. 635.18 (3) (a) of the statutes is amended to read:

635.18 **(3)** (a) Except as provided in par. (b), ~~a small employer~~ an insurer may not, directly or indirectly, enter into any contract, agreement or arrangement with an intermediary that provides for or results in compensation to ~~an~~ the intermediary for the sale of a health benefit plan that varies according to the health ~~status~~ condition, claims experience, industry, occupation or geographic ~~location~~ area of the ~~small~~ employer ~~or~~, eligible employes, insured individual or dependents.

SECTION 65. 635.18 (3) (b) of the statutes is amended to read:

635.18 **(3)** (b) Payment of compensation on the basis of percentage of premium is not a violation of par. (a) if the percentage does not vary based on the health ~~status~~ condition, claims experience, industry, occupation or geographic area of the ~~small~~ employer ~~or~~, eligible employes, insured individual or dependents.

SECTION 66. 635.18 (3) (c) of the statutes is repealed.

SECTION 67. 635.18 (4) of the statutes is amended to read:

635.18 **(4)** ~~A small employer~~ An insurer may not terminate, fail to renew or limit its contract or agreement of representation with an intermediary for any reason related to the health ~~status~~ condition, claims experience, occupation or geographic

~~location~~ area of the ~~small~~ employers ~~or~~, eligible employes, insured individuals or ~~their~~ dependents placed by the intermediary with the ~~small employer~~ insurer.

SECTION 68. 635.18 (5) of the statutes is amended to read:

635.18 **(5)** ~~A small employer~~ An insurer or an intermediary may not induce or otherwise encourage ~~a small~~ an employer to separate or otherwise exclude an employe from health coverage or benefits provided in connection with the employe's employment.

SECTION 69. 635.18 (6) of the statutes is amended to read:

635.18 **(6)** Denial by ~~a small employer~~ an insurer of an application for coverage ~~from a small employer~~ under a health benefit plan shall be in writing and shall state the reason or reasons for the denial.

SECTION 70. 635.18 (7) of the statutes is amended to read:

635.18 **(7)** A 3rd–party administrator that enters into a contract, agreement or other arrangement with ~~a small employer~~ an insurer to provide administrative, marketing or other services related to the offering of health benefit plans to ~~small~~ employers or individuals in this state is subject to this ~~subchapter~~ chapter as if it were ~~a small employer~~ an insurer.

SECTION 71. 635.18 (8) of the statutes is amended to read:

635.18 **(8)** The commissioner may by rule establish additional standards to provide for the fair marketing and broad availability of health benefit plans to ~~small~~ employers and individuals in this state, including requirements designed to prevent evasion of the purposes of this chapter.

SECTION 72. Subchapter II of chapter 635 [precedes 635.20] of the statutes, as affected by 1995 Wisconsin Act 289, is repealed.

SECTION 73. Nonstatutory provisions.

1 (1) RISK ADJUSTMENT COMMITTEE. The commissioner of insurance shall appoint
2 a committee on risk adjustment under section 15.04 (1) (c) of the statutes, consisting
3 of 5 to 8 members, to advise the commissioner on, and to assist the commissioner in
4 developing rules for, the group risk adjustment mechanism under section 635.06 (4)
5 of the statutes, as created by this act. The commissioner shall appoint at least 5
6 representatives of insurers to be members of the committee.

7 (2) RISK ADJUSTMENT MECHANISM EMERGENCY RULE–MAKING AUTHORITY. Using the
8 procedure under section 227.24 of the statutes, the commissioner of insurance may
9 promulgate rules under section 635.06 (4) (e) of the statutes, as created by this act,
10 for the period before the effective date of the permanent rules promulgated under
11 section 635.06 (4) (e) of the statutes, as created by this act, but not to exceed the
12 period authorized under section 227.24 (1) (c) and (2) of the statutes.
13 Notwithstanding section 227.24 (1) and (3) of the statutes, the commissioner is not
14 required to make a finding of emergency.

15 (3) EVALUATION OF MARKET REFORMS.

16 (a) The commissioner of insurance shall evaluate the effectiveness of the health
17 insurance market reforms under chapter 635 of the statutes, as affected by this act,
18 and under the federal Health Insurance Portability and Accountability Act of 1996,
19 P.L. 104–191, including the effectiveness of the reforms with respect to all of the
20 following:

21 1. Accessibility of health insurance coverage, including such accessibility for
22 persons who reside in rural areas of the state.

23 2. Availability of health insurance coverage for uninsured persons.

24 3. Affordability of health insurance coverage.

(b) The commissioner shall submit a report of the results of the evaluation and any recommendations to the legislature in the manner provided under section 13.172 (2) of the statutes no later than the first day of the 24th month beginning after publication.

SECTION 74. Initial applicability.

(1) This act first applies to all of the following:

(a) Except as provided in paragraphs (b) and (c), health benefit plans that are issued or renewed, and self–insured health plans that are established, extended, modified or renewed, on the effective date of this paragraph.

(b) Health benefit plans covering employes who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified or renewed.

(c) Self–insured health plans covering employes who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified or renewed.

SECTION 75. Effective dates. This act takes effect on the first day of the 7th month beginning after publication, except as follows:

(1) SECTION 73 (1) and (2) of this act takes effect on the day after publication.

1 (2) The repeal of section 635.08 (1) (b) of the statutes takes effect on the 31st
2 day after the day on which the commissioner of insurance certifies to the revisor of
3 statutes under section 632.898 (7) of the statutes, as affected by this act, that section
4 635.08 (1) (b) of the statutes, as created by this act, is not necessary for the purpose
5 for which it was intended.

6 **(END)**