



ENGROSSED 2017 ASSEMBLY BILL 920

February 21, 2018 - Printed by direction of SENATE CHIEF CLERK.

1 **AN ACT to create** 146.79, 600.01 (1) (b) 13. and 601.415 (14) of the statutes;
2 **relating to:** employer groups for self-funded health care coverage and
3 granting rule-making authority.

Analysis by the Legislative Reference Bureau

Engrossment information:

The text of Engrossed 2017 Assembly Bill 920 consists of the following documents adopted in the assembly on February 20, 2018: the bill as affected by Assembly Amendments 1, 4, and 5. The text also includes the February 21, 2018, chief clerk's correction to Assembly Amendment 5 to Assembly Bill 920.

Content of Engrossed 2017 Assembly Bill 920:

This bill allows the establishment of employer groups to jointly provide health care benefits on a self-funded basis to the employers' eligible employees and their dependents under a health care benefit arrangement. Two or more employers that are members of the same chamber of commerce or industry-based association may form an employer group. Employer groups that provide evidence to the commissioner of insurance that they have formed and are able to comply with the requirements in the bill qualify to participate in the self-funded health benefits project. To qualify as an employer group, the employer group must create and maintain a formal organizational structure, control functions and activities of the employer group through nomination and election of representatives, and be formed from a chamber of commerce or industry-based association that meets certain criteria such as being actively in existence for at least five years.

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Each employer group in the project must, among other requirements, do all of the following: determine all matters necessary for administration and operation of the employee health care benefit arrangement; determine, based on an actuary's recommendations, the amount that each employer must contribute for the health care benefit arrangement, administrative expenses, and excess or stop-loss coverage; establish a minimum participation period of no less than three years for an employer to participate unless the employer meets special circumstances established by the employer group; specify the procedures to be followed in the event of insolvency; and report annually to the commissioner of insurance on the stability of the group and its finances. The employer group may specify minimum participation requirements that employers must meet to participate, but must, with certain exceptions, allow any employer that is a member of the same chamber of commerce or industry-based association and agrees to comply with those requirements to participate. If an employer does not pay the required contribution, the employer group must terminate the participation of the employer. If an employer terminates participation in an employer group voluntarily or involuntarily, the employer is responsible for contribution amounts required during the employer's participation and the employer's proportionate share of the cost of claims payable before the termination.

Each employer group in the project must require each of its participating employers to offer the same health care benefits or health care benefit arrangements with minimally different actuarial values to all eligible employees and dependents. The health care benefit arrangement must include coverage of certain individuals, treatments, and conditions that private health insurance is required to cover under current law, including the following: extension of coverage of children with disabilities; coverage of individuals who have been victims of domestic violence and covering illness or disease resulting from abuse or domestic abuse; extension of dependent child coverage to a certain age; coverage of a spouse or dependent under certain family circumstances; coverage of HIV infection or illness or a medical condition arising out of HIV infection; coverage of adopted children; coverage of certain mental health treatments; coverage of services provided by a certain type of provider, including chiropractors, if the plan generally covers the services; and coverage of home care, skilled nursing care, kidney disease treatment, newborn infants, grandchildren, diabetes equipment and supplies, maternity, mammograms, drugs for HIV infection treatment, lead poisoning screening, correction of temporomandibular disorders, hospital and ambulatory surgery center charges, anesthetics for certain dental care, autism spectrum disorders, breast reconstruction, certain immunizations, students on medical leave, hearing aids and cochlear implants for children, colorectal cancer screening, and contraceptives. The bill also imposes on health care benefit arrangements certain cost-sharing requirements on oral and injected chemotherapy and prohibits the arrangements from requiring individuals to have or from basing coverage on genetic testing.

Each employer group in the program is required to pay no more than \$50,000 in benefits for each covered individual in a calendar year, unless an independent actuary confirms the employer group is financially capable of paying more. The

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employer group is required to obtain excess or stop-loss coverage in an amount sufficient to pay the excess amount of claims.

The bill specifies that the employer group is not considered an insurer, and the health care benefit arrangement is not considered an insurance contract, for any purpose. With limited exceptions, insurance statutes and rules do not apply to an employer group or a health care benefit arrangement. The commissioner is allowed to examine the solvency of an employer group and promulgate rules regarding the solvency of employer groups and may require an employer to take corrective action or impose another enforcement action on employer groups based on violations of any rules the commissioner promulgates. The commissioner is also allowed to promulgate rules to implement federal law if the federal Department of Labor promulgates a final rule that allows the states to have regulatory authority over association health plans.

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

1 **SECTION 1.** 146.79 of the statutes is created to read:

2 146.79 **Employer group self-funded health benefits project. (1)**

3 DEFINITION. In this section, “eligible employee” means an employee who works on a
4 permanent basis and has a normal work week of 30 or more hours and includes all
5 of the following, if included as an employee under the health care benefit
6 arrangement under this section:

7 (a) A sole proprietor.

8 (b) A business owner, including the owner of a farm business.

9 (c) A partner of a partnership.

10 (d) A member of a limited liability company or a corporation defined under 26
11 USC 1361 (a) (1).

12 **(2) EMPLOYER GROUPS; QUALIFICATION.** (a) Two or more employers that are
13 members of the same chamber of commerce or industry-based association may form
14 an employer group to establish and administer an employee health care benefit

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1 arrangement to jointly provide health care benefits on a self-funded basis to eligible
2 employees of employers in the group and the dependents of those eligible employees.

3 (am) To qualify under par. (b), an employer group shall satisfy all of the
4 following:

5 1. The employer group creates and maintains a formal organizational structure
6 with a governing body and an indication of formality, such as having by-laws.

7 2. The employers in the employer group control functions and activities of the
8 employer group, including establishment and maintenance of the employee health
9 care benefit arrangement, directly or indirectly through nomination and election of
10 representatives that control the employer group or association.

11 3. The chamber of commerce or industry-based association from which the
12 employer group is formed is actively in existence for at least 5 years before providing
13 evidence to the commissioner under par. (b), has at least 5 members for the 5 years
14 before providing evidence to the commissioner under par. (b), and is formed and
15 maintained in good faith for purposes other than obtaining or providing health
16 benefits.

17 (b) Employer groups that provide evidence to the commissioner of insurance
18 that they have formed and are able to comply with the requirements of this section
19 qualify to participate in the project under this section. When employer groups have
20 qualified under this paragraph, the commissioner of insurance shall submit a notice
21 to the legislative reference bureau for publication in the Wisconsin Administrative
22 Register that lists the employer groups that have qualified and the date on which
23 each group provided the necessary evidence of compliance.

24 **(3) EMPLOYER GROUP DUTIES AND POWERS.** (a) Each employer group qualified
25 under sub. (2) (b) shall do all of the following:

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1 1. Determine all matters necessary for the administration and operation of its
2 employee health care benefit arrangement.

3 2. Designate an agent for service of process, notice, or demand.

4 4. Employ or contract with an actuary to make recommendations, in
5 accordance with generally accepted actuarial principles, as to the sufficient amount
6 of funding for the employee health care benefit arrangement. The employer group
7 shall ensure that the actuary making recommendations under this subdivision is in
8 good standing with the Academy of Actuaries, has the skills and knowledge
9 necessary to perform the analyses and make the recommendations, and is
10 performing the analyses and certifications based on sound actuarial principles. The
11 employer group satisfies the requirement under this subdivision if the employer
12 group contracts with an insurer or a 3rd-party administrator that employs an
13 actuary.

14 5. Determine, based on the actuary's recommendations under subd. 4., the
15 amount that each employer that is participating in the employer group shall
16 contribute to self-fund the employee health care benefit arrangement; to pay
17 administrative expenses, including the actuary's compensation; and to purchase
18 excess or stop-loss coverage, as described under sub. (5) (b). The contribution
19 amount under this subdivision may vary by employer based on criteria developed by
20 the employer group. An employer group may require employers in the employer
21 group to contribute payments for establishing a surplus fund and may levy an
22 assessment whenever the amount of any loss or expense that is due exceeds the
23 assets of the employer group or the surplus fund amount established by the employer
24 group is impaired.

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1 6. Establish a minimum participation period for an employer's participation in
2 the employer group, which shall be the same length for each employer participating
3 in the employer group and may not be less than 3 years. An employer group may
4 specify circumstances under which a participating employer may discontinue
5 participation in the employer group before the minimum participation period
6 established under this subdivision ends without forfeiting all or a portion of the
7 amount paid by the employer under sub. (4) (a) 2.

8 7. Annually submit a report to the commissioner of insurance describing the
9 stability of the employer group and the finances of the employer group and
10 containing any information specified by the commissioner by rule under sub. (5m).

11 8. Specify in an agreement among the employers in the employer group or in
12 the by-laws of the employer group the procedures to be followed by and
13 responsibilities of the involved parties in the event of insolvency or pending
14 insolvency of the employer group.

15 (b) An employer group qualified under sub. (2) (b) may specify minimum
16 participation requirements that an employer is required to satisfy to participate in
17 the employer group. Except as provided under sub. (4) (b), an employer group
18 qualified under sub. (2) (b) shall allow any employer that is a member of the same
19 chamber of commerce or industry-based association as the other group members and
20 that agrees to comply with the participation requirements specified under this
21 paragraph to participate in the employer group.

22 (c) If an employer group qualified under sub. (2) (b) seeks to contract with a
23 3rd-party administrator to administer any part of the health care benefit
24 arrangement, the employer group shall contract with a 3rd-party administrator that
25 is registered to do business in this state. A contract between an employer group and

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1 a 3rd-party administrator that relates to the administration of the payment of
2 claims shall specify terms for the resolution of claims upon termination of the
3 contract with that 3rd-party administrator.

4 (4) EMPLOYER REQUIREMENTS. (a) An employer group qualified under sub. (2)
5 (b) shall require each of its participating employers to do all of the following:

6 1. Offer the same health care benefits, or health care benefit arrangements
7 with a de minimis difference in actuarial value, to all of the employer's eligible
8 employees and all of the eligible employees' dependents.

9 2. Participate for at least the minimum participation period specified by the
10 employer group under sub. (3) (a) 6. An employer group may require employers that
11 desire to participate in the employer group to pay an amount that is forfeited to the
12 employer group if the employer's participation terminates voluntarily or
13 involuntarily before the employer's minimum participation period ends.

14 (b) Subject to any policy created by the employer group regarding late
15 payments, an employer group qualified under sub. (2) (b) shall terminate an
16 employer's participation in the employer group if the employer fails to pay a
17 contribution required by the employer group under sub. (3) (a) 5.

18 (c) An employer group qualified under sub. (2) (b) shall hold an employer whose
19 participation in the employer group terminates voluntarily or involuntarily
20 responsible for all of the following:

21 1. Any contribution amounts required during the employer's period of
22 participation.

23 2. The employer's proportionate share of the cost of any claims payable by the
24 employer group that were incurred before the termination of the employer's
25 participation.

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1 **(5) COVERED BENEFITS; PAYMENT OF CLAIMS.** (a) An employer group may provide
2 a choice of health care benefit plans to employers but each employer that participates
3 in the employer group shall offer the same health care benefits, or health care
4 arrangement with a de minimis difference in actuarial value, to all employees and
5 dependents of the employer.

6 (am) 1. An employer group qualified under sub. (2) (b) may not exclude coverage
7 under a health care benefit arrangement for diagnosis and treatment of a condition
8 or complaint by a licensed chiropractor within the scope of the chiropractor's
9 professional license if the health care benefit arrangement covers diagnosis and
10 treatment of a condition or complaint by a licensed physician or osteopath, even if
11 different nomenclature is used to describe the condition or complaint. The health
12 care benefit arrangement may not require examination by or referral from a
13 physician before allowing coverage of chiropractic care under this paragraph. This
14 paragraph does not prohibit any of the following:

15 a. Application of deductibles or coinsurance under the health care benefit
16 arrangement to chiropractic care if deductibles or coinsurance apply equally to
17 physician care.

18 b. Application of cost containment or quality assurance measures to
19 chiropractic services in a manner that is consistent with cost containment or quality
20 assurance measures applied to physician services.

21 2. An employer group qualified under sub. (2) (b) may not do any of the following
22 under a health care benefit arrangement that covers diagnosis and treatment of
23 conditions or complaints by a licensed chiropractor within the scope of the
24 chiropractor's professional license:

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1 a. Restrict or terminate coverage for the treatment of a condition or complaint
2 by a licensed chiropractor within the scope of the chiropractor's professional license
3 other than on the basis of an examination, evaluation, or recommendation by
4 another licensed chiropractor or a peer review committee that includes a licensed
5 chiropractor.

6 b. Exclude or restrict coverage of a health condition under the health care
7 benefit arrangement solely because the condition may be treated by a chiropractor.

8 (ar) Each employer group qualified under sub. (2) (b) shall offer under each
9 employee health care benefit arrangement coverage of individuals, conditions, and
10 services as described in ss. 631.89, 631.93 (2), 631.95, 632.85 (2), 632.867, 632.87,
11 632.88, 632.885, 632.89 (2), 632.895, 632.896, and 632.897.

12 (b) An employer group qualified under sub. (2) (b) shall pay no more than
13 \$50,000 in benefits on a self-funded basis incurred in a calendar year for each
14 individual covered under its employee health care benefit arrangement, unless the
15 employer group is financially capable of paying more than \$50,000 in benefits per
16 individual per calendar year as confirmed by an independent actuary. Each
17 employer group shall obtain excess or stop-loss coverage through an insurer
18 authorized to do business in this state in an amount that is sufficient to pay claims
19 that exceed the amount that the employer group will pay on a self-funded basis.

20 (c) If an employer group qualified under sub. (2) (b) ceases operating its
21 employee health care benefit arrangement, the employer group is responsible for
22 paying eligible claims incurred during the time in which the employee health benefit
23 arrangement was operating.

24 **(5m)** COMMISSIONER OVERSIGHT. (a) The commissioner of insurance may
25 examine the solvency of an employer group qualified under sub. (2) (b), including the

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1 surplus funds available to the employer group and the levels and cost of reinsurance,
2 using statutory accounting principles. The commissioner may promulgate rules
3 regarding the solvency of employer groups qualified under sub. (2) (b). The
4 commissioner may require an employer group to take corrective action, issue an
5 order, or initiate an enforcement proceeding described under s. 601.41 (4) to remedy
6 a violation of rules promulgated under this paragraph.

7 (b) If, after the effective date of this paragraph [LRB inserts date], the
8 federal department of labor publishes a final rule allowing states regulatory
9 authority over association health plans, the commissioner of insurance may
10 promulgate rules to implement the federal law.

11 **(6) EXEMPTION FROM INSURANCE REGULATION.** Notwithstanding 29 USC 1144 (b)
12 (6) (A) and except as provided in sub. (5m), chs. 600 to 646 and any rules promulgated
13 under chs. 600 to 646 do not apply to an employer group or an employee health care
14 benefit arrangement under this section. An employer group may not be considered
15 an insurer, and an employee health care benefit arrangement may not be considered
16 an insurance contract, for any purpose under the statutes.

17 **SECTION 2.** 600.01 (1) (b) 13. of the statutes is created to read:

18 600.01 (1) (b) 13. Any employer group or employee health care benefit
19 arrangement under s. 146.79.

20 **SECTION 3.** 601.415 (14) of the statutes is created to read:

21 601.415 (14) **QUALIFICATION OF EMPLOYER GROUPS.** The commissioner shall
22 qualify employer groups as specified under s. 146.79 (2) (b).

23 **(END)**