Committee Meeting Attendance Sheet

Committee on Agriculture, Financial Institutions and Insurance

Date: December 16th, 2003 **Meeting Type:** Public, Rule Revision

Location: Room 417 South State Capitol

Committee Member	Present	Absent	Excused
Senator Dale Schultz, Chair	☑	☐	☐
Senator Ronald Brown	☑	☐	☐
Senator Neal Kedzie	☑	☐	☐
Senator David Hansen	☑	☐	☐
Senator Julie Lassa	☑	☐	☐

Totals: _____ _____ _____

John O'Brien
Committee Clerk

Senate Committee on Agriculture, Financial Institutions and Insurance

Room 18 South State Capitol, PO Box 7882, Madison WI 53707-7882
(608) 266-0703

Senator Dale W. Schultz, Chairman

December 16, 2003

COMMITTEE BALLOT

The Senate Committee on Agriculture, Financial Institutions and Insurance after public hearing on Clearinghouse Rule 03-055,

Moves that:

A. The Senate Committee on Agriculture, Financial Institutions and Insurance requests that the Commissioner of Insurance modify Clearinghouse Rule 03-055 as follows:

1. Including the Small Employer Uniform Employee Application for Group Health Insurance form (application form) submitted with Clearinghouse Rule 03-55 as an appendix to ch. Ins 8 so that the form is included in the Wisconsin Administrative Code in compliance with ss. 601.41 (8) (b) and 635.10, Stats., which required the Commissioner to develop the application form by administrative rule.

2. Making editorial and stylistic changes to consolidate items of information requested on the application form and shorten the application form.

3. Inserting a line on each page of the application form for the employee's name.

4. Reordering the current proposed sections of the application form to consolidate health questions and place them at the front of application form.

B. If the Commissioner of Insurance fails to notify the Committee in writing by the close of business on Friday December 19, 2003, that the Commissioner will submit modifications to the Committee by February 1, 2004 accomplishing these changes, the Committee objects to Clearinghouse Rule 03-55 in its entirety under s. 227.19 (4) (d) 3., 4., and 6., Stats., on the grounds that the rule fails to comply with legislative intent, is in conflict with state law, is arbitrary and capricious, and imposes undue hardships.

Committee Member	**AYE**	**NAY**	**NOT VOTING**
Senator Dale Schultz	☒	☐	☐

Dale W. Schultz

Senator Dale Schultz

Ballots must be returned to Senator Schultz's office by noon on Wednesday, December 17, 2003.

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Committee Member	**AYE**	**NAY**	**NOT VOTING**
Senator Ron Brown	☒	☐	☐

Ron Brown

Senator Ron Brown

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Committee Member	**AYE**	**NAY**	**NOT VOTING**
Senator Julie Lassa	☒	☐	☐

Julie M Lassa

Senator Julie Lassa

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Committee Member	**AYE**	**NAY**	**NOT VOTING**
Senator Neal Kedzie	☒	☐	☐

Senator Neal Kedzie

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Committee Member	**AYE**	**NAY**	**NOT VOTING**
Senator Dave Hansen	☐	☒	☐

Sen. Dave Hansen

Senator Dave Hansen

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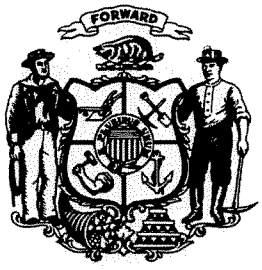


Senate Committee on Agriculture, Financial Institutions and Insurance

Room 18 South State Capitol, PO Box 7882, Madison WI 53707-7882
(608) 266-0703

Senator Dale W. Schultz, Chairman

Committee Clerk, John O'Brien

November 19, 2003

Mr. Jorge Gomez, Commissioner
Office of the Commissioner of Insurance
121 E. Wilson Street
Madison, WI 53702

Dear Commissioner Gomez,

On October 29th, 2003 Clearinghouse Rule 03-055, related to "Small Employer Uniform Employee Health Application and Rule" was referred to the Senate Committee on Agriculture, Financial Institutions and Insurance.

The 30-day committee review period would normally expire on Friday, November 28th, 2003.

At our request, the Legislative Council Staff reviewed the rule and has expressed some concerns, which may need to be addressed. The Committee is reviewing the concerns of the Legislative Council staff and others who have commented on the rule at the request of the committee chairman. We will keep your office informed if the Committee feels revisions to this rule may be in order.

This letter is to inform you that the committee by this correspondence is exercising its authority to extend the review period of CR 03-055 by 30 days.

Thank ~~you,~~

Senator Dale Schultz, Chairman

Cc.
Sen. Chief Clerk
Legislative Council Staff
Rep. Bonnie Ladwig
Committee Members

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

CREATING A RULE

To create Ins 8.49, Wis. Adm. Code, relating to Small Employer Uniform Employee Application.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss 601.41(3), 601.41 (8), 635.10, 635.18 (8), Stats.

Statutes interpreted: ss. 635.10, Stats.

In accordance with s. 601.41 (8) and s. 635.10, Stats., the Office is statutorily required to develop a rule and the uniform employee application form for group health insurance that is to be used by small employer insurers for small employer applicants. In compliance with s. 601.41(8), Stats., the Office, with consultation of the life and disability advisory council, convened a taskforce with representatives of small employers, licensed intermediaries and small employer insurers to obtain information relating to a proposed uniform employee application form. The taskforce made recommendations to the Office for its consideration in the development of the small employer uniform employee application.

The intent of the legislation was two-fold: to reduce the number of forms employees were required to complete when a small employer applied for group health insurance and to permit small employers to seek multiple statements of premium from

different small employer insurers with one form. Having a uniform employee application that could be used to obtain multiple statements of premium also has the benefit of decreasing the amount of time spent by the small employer in obtaining the application information since the form may be copied and submitted simultaneously to several insurers.

To address the concerns of the small employers, licensed intermediaries and small employer insurers, the Office, in addition to drafting the uniform employee application, also drafted the rule governing the use and management of the application process. The proposed regulations establish the following: copies of the form shall be accepted as though it were an original; duration for use of the information contained within the application form; and small employer insurers are required to share copied forms, in accordance with the applicant's authorization, with other named insurers within 5 business days as requested in writing by the small employer. The intent is to facilitate a timely exchange of the applications so that the small employer is able to receive the statement of premium necessary to make an informed decision regarding the purchase of group health insurance.

SECTION 1. Section Ins 8.49 is created to read:

Ins 8.49 Uniform employee application form. (1) (a) In accordance with s. 635.10, Stats., small employer insurers shall use the small employer uniform employee application form as the only acceptable form when small employers apply for coverage from small employer insurers. Small employer insurers shall implement procedures and policies necessary to use the small employer uniform employee application form.

(b) Small employer insurers shall treat and accept a copy of the uniform employee application as an original.

(c) The contents of the uniform small employer application shall not vary from the text or format including bold character, line spacing, the use of boxes around text and shall use a type size of at least 10 points as delineated in form OCI 26-501.

(d) Small employer insurers and licensed intermediaries may pre-print the name of the small employer insurer on the uniform employee application provided that the form contains at least 3 additional spaces to insert the names of insurers to whom the uniform applications may be sent and the form complies with par. (c).

Note: A copy of the uniform employee application form OCI 26-501 (c. 8/2003), required in par. (a), may be obtained at no cost from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison WI 53707-7873, or at the Office's web address: oci.wi.gov.

(2) (a) The information contained within each uniform employee application shall be considered current information by the small employer insurer if the information is received by the small employer insurer within 45 days of completion of the earliest signed and completed uniform employee application form. For the period of time that the information contained within the uniform employee application is considered current, small employer insurers may not require a small employer employee to complete a new application form or any document, addendum or certification representing that the information contained in the completed uniform employee applications is current.

(b) A small employer insurer may accept and utilize information provided by a small employer employee subsequent to the date the employee signed the completed

application if the employee is providing the insurer with additional or modified information.

(c) A small employer insurer may require small employer employees to complete and submit new uniform employee applications if either of the following occurs:

1. The authorization signed by the employees does not include the name of the small employer insurer that the small employer is requesting provide it with an underwritten premium amount and coverage.

2. The completed uniform employee applications are received by the small employer insurer 45 or more days after the earliest date of the completed signed uniform employee application.

(3) (a) Small employer insurers that receive a written request from a small employer to forward a copy of the completed uniform employee applications to a different small employer insurer listed within the authorization section of the application shall forward the copy of the uniform employee applications within 5 business days from receipt of the request. The small employer insurer shall notify the employer, as soon as practicable, if the small employer insurer is unable to comply with the request because the small employer has requested that information be sent to a small employer insurer not identified within the authorization.

(b) An intermediary shall forward, within 5 business days from receipt of the applications, copies of the uniform employee applications to all small employer insurers identified within the uniform employee application authorization to receive the applications, or to an authorized representative of each small employer insurer.

The intermediary may withhold distribution to a small employer insurer, or the insurer's authorized representative, at the request of the small employer.

(c) Completed uniform employee applications shall be maintained by small employer insurers and licensed intermediaries, as applicable, in accordance with subch. V of ch. Ins 25.

(4) (a) Small employer insurers shall either state the premium to the small employer within 10 business days from receipt of all pertinent information required for its underwriting of the small employer's application for group health insurance, including completed uniform employee applications, or deny the application in accordance with s. 635.18 (6).

(b) Small employer insurers shall make a reasonable effort to promptly obtain information it determines is necessary to make an underwriting decision including the information described in par. (a).

SECTION 2. EFFECTIVE DATE. This rule shall take effect on the first day of the month following publication in the Wisconsin administrative register as provided in s. 227.22(2)(intro.), Stats.

Dated at Madison, Wisconsin, this _____ day of _____, 2003.

_____

Jorge Gomez
Commissioner of Insurance

Wisconsin Department of Administration
Division of Executive Budget and Finance
DOA-2047 (R10/2000)

FISCAL ESTIMATE WORKSHEET — 2001 Session

Detailed Estimate of Annual Fiscal Effect

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 8.49**

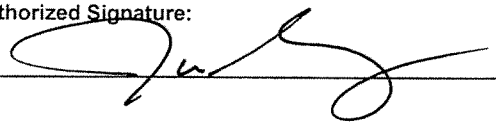
Subject
Small Employer Group Health Insurance Rule and Application

One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):
None

Annualized Costs:	Annualized Fiscal impact on State funds from: Increased Costs	Decreased Costs
A. State Costs by Category		
State Operations - Salaries and Fringes	$ 0	$ -0
(FTE Position Changes)	(0 FTE)	(-0 FTE)
State Operations - Other Costs	0	-0
Local Assistance	0	-0
Aids to Individuals or Organizations	0	-0
TOTAL State Costs by Category	$ 0	$ -0
B. State Costs by Source of Funds	**Increased Costs**	**Decreased Costs**
GPR	$ 0	$ -0
FED	0	-0
PRO/PRS	0	-0
SEG/SEG-S	0	-0
C. State Revenues Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, etc.)	**Increased Rev.**	**Decreased Rev.**
GPR Taxes	$ 0	$ -0
GPR Earned	0	-0
FED	0	-0
PRO/PRS	0	-0
SEG/SEG-S	0	-0
TOTAL State Revenues	$ 0 None	$ -0 None

NET ANNUALIZED FISCAL IMPACT

	STATE	LOCAL
NET CHANGE IN COSTS	$ None 0	$ None 0
NET CHANGE IN REVENUES	$ None 0	$ None 0

Prepared by:	Telephone No.	Agency
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature: 	Telephone No. (608) 267-1233	Date (mm/dd/ccyy) 10/23/02

Wisconsin Department of Administration
Division of Executive Budget and Finance
DOA-2048 (R10/2000)

FISCAL ESTIMATE — 2001 Session

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 8.49**

Subject
Small Employer Group Health Insurance Rule and Application

Fiscal Effect

State: ☒ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☒ No local government costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected: ☐ Towns ☐ Villages ☐ Cities ☐ Counties ☐ Others _____ ☐ School Districts ☐ WTCS Districts

Fund Sources Affected: ☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

The proposed rule provides the guidelines for utilizing the small employer uniform application. The Office is required to review the form on a bi-annual basis. There is no financial effect to the State or small employers. Rather, the utilization of the uniform small employee application is intended to save small employers money by utilizing one form for obtaining accurate premiums from multiple small employer insurers.

Long-Range Fiscal Implications

None

Prepared by:	Telephone No.	Agency
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)
	(608) 267-1233	10/8/07

SMALL EMPLOYER UNIFORM EMPLOYEE APPLICATION FOR GROUP HEALTH INSURANCE

Ref: Section Ins 8.49, Wis. Adm. Code, and Sections 601.41 (8), 635.10, Wis. Stats.

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-3585
Web Address: oci.wi.gov

Pursuant to s. 635.10, Wis. Stat., every small employer insurer shall use the uniform employee application form when a small employer applies for coverage under a group health benefit plan offered by the small employer insurer. Section Ins 8.49, Wis. Adm. Code, delineates the requirements for utilization, timing and maintaining the uniform application forms.

This form is designed for an employer's initial application for coverage. Please contact your agent or the insurer to determine if this form should be used in other situations once the group is enrolled with the insurer.

EMPLOYER INFORMATION – To be filled out by Employer

Employer Name _____ **Group Number** _____ **Division Number** _____

Employee Class _____

Total Number of Permanent Employees Who Have a Normal Work Week of 30 or More Hours _____

Names of Insurers to whom information may be released:

Insurer: _____ **Insurer:** _____
Insurer: _____ **Insurer:** _____

I. EMPLOYEE INFORMATION

Employee Instructions: Please print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought.

Employee's First Name, Middle Initial and Last Name: _____
Social Security No.: _____ Birth Date: _____ Sex: _____ Height and Weight: _____

Street or Post Office Address: _____
City: _____ County: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Email: _____
[ ] Home or [ ] Work

1. For your current employer: What was your first day of employment? ___/___/___

   How many hours, on average, do you work each week? _____ What is your annual salary? _____

2. Are You:

   a) [ ] Single [ ] Married [ ] Legally Separated [ ] Divorced [ ] Widow or Widower
   If you are married, legally separated, divorced or widowed, please indicate the date that the event occurred: _____
   If you are married, please indicate the county and state, or country in which you were married: _____
   If you are married, please indicate your former or maiden name: _____

   b) A Retiree? [ ] Yes [ ] No

   c) On COBRA or State Continuation? [ ]Yes [ ] No
   If yes, start date and reason: _____

II. WAIVER OF COVERAGE

I understand that I am eligible to apply for group health insurance through my employer. I do **NOT** want, and hereby waive, group health insurance for (check the box that applies):

[ ] Waiving for myself [ ] Waiving for my spouse [ ] Waiving for my dependent child(ren)
[ ] Waiving for me, my spouse and my dependent child(ren)

I am waiving group health insurance because (check all that apply):

[ ] I, the employee, am covered or will be covered under another plan that is not sponsored by my employer. I am **not** enrolled for coverage under the Health Insurance Risk-Sharing Plan (HIRSP). If currently covered, please attach a copy of your identification card for that plan.

[ ] I, the employee, do not have a risk characteristic or other attribute that would be the sole cause for the small employer insurer to make a decision with respect to premiums or eligibility for a policy that is adverse to the small employer.

[ ] My spouse is covered or will be covered under another plan that is not sponsored by this employer. My spouse is **not** enrolled for coverage under the Health Insurance Risk-Sharing Plan (HIRSP). If currently covered, please attach a copy of your spouse's identification card for that plan.

[ ] My dependent child(ren) is covered or will be covered under another plan that is not sponsored by my employer. My dependent child(ren) is **not** enrolled for coverage under the Health Insurance Risk-Sharing Plan (HIRSP). If currently covered, please attach your identification card for that plan. Please list the name(s) of the child(ren) for whom coverage is being waived.

[ ] I am **not** enrolled under the Health Insurance Risk-Sharing Plan (HIRSP) and the annualized premium contribution to be paid by me on behalf of myself or my dependent spouse and child(ren) would exceed **10%** of my **annualized gross earnings from this employer**.

[ ] Other reason (Please provide a written reason for waiving coverage):

_____

_____

_____

WAIVER: I certify that I have been given the opportunity to apply for group health insurance and decline to enroll as indicated above, on behalf of myself, my spouse and my dependent child(ren). I understand that by signing this waiver, I, my spouse, and my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the insurer(s) into waiving or declining the group health insurance. If in the future I apply for coverage, I, my spouse, or any of my dependent child(ren) may be treated as a late enrollee and subject to postponement or an exclusion of coverage for preexisting conditions for a period of up to 18 months. This period may be offset by the time I, my spouse or my dependent child(ren) was covered under a qualified health plan.

I understand that if I am declining enrollment for myself, my spouse, or my dependent child(ren) because of other health insurance, I may in the future be able to enroll myself, my spouse, or my dependent child(ren) in this plan, provided that I request enrollment within 30 days after my other health coverage ends. In addition, if I gain a dependent spouse or child(ren) as a result of marriage, birth, adoption, or placement for adoption, I understand that I may be able to enroll myself, my spouse and my dependent child(ren), provided that I request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Signature of Employee: _____ Date Signed: _____

Signature of Spouse: _____ Date Signed: _____

III. TYPE OF HEALTH COVERAGE

Please select the type of health insurance coverage for which you are applying:

[ ] Employee Only [ ] Employee and Spouse [ ] Employee and Dependent Child(ren)

[ ] Employee, Spouse and Dependent Child(ren)

IV. DEPENDENT INFORMATION

a) List all dependents, spouse and child(ren) applying for insurance. The form continues on the next page. If you need additional space, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet).

Name (First; M.I.; Last)	Sex	Social Security Number	Relationship	Birth Date (Mo/Day/Yr)	Height Weight	Full-Time Student (if over age 18)
			Spouse			
			[ ] Child [ ] Stepchild [ ] Grandchild [ ] Other _____			School _____ Graduation Date _____ Credits/Semester
			[ ] Child [ ] Stepchild [ ] Grandchild [ ] Other _____			School _____ Graduation Date _____ Credits/Semester

b) If required by the insurer, for a dependent child(ren) who is 18 years or age or older and who are full-time students, do you provide at least 50% of the dependent's support? [ ] Yes [ ] No.
If "No," provide the name(s) of the dependent child(ren) for whom you do **not** provide 50% support?

_____

_____

c) Does the dependent child(ren) named within this application live with you at the address shown above? [ ] Yes [ ] No
If not, please list name(s) and the dependent child(ren)'s address(es):

_____

_____

_____

d) Is anyone named in this application now disabled, mentally incompetent or unable to perform normal work or age-related activities? [ ] Yes [ ] No

If yes, please identify name(s), health condition(s), date(s) of disability and name(s) and address(es) of the attending physician(s):

_____

_____

_____

e) If there is a stipulation in a legal decree or court order stating who is responsible for providing health insurance of the named dependent child(ren), please indicate name of the person who has primary custody of the dependent child(ren) and the name of the responsible person for health insurance:

_____

_____

_____

V. MEDICARE INFORMATION

If you need to complete this Section V for more than one person, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet).

Are you, your spouse or your child(ren) covered by Medicare Part A? [ ] Yes [ ] No Medicare Part B? [ ] Yes [ ] No

Name of person covered by Medicare: _____

If Yes, reason for Medicare: [ ] Over Age 65 [ ] Disability [ ] End-Stage Renal Disease (ESRD) [ ] Disability and ESRD

Medicare Part A Effective Date: _____ Medicare Part B Effective Date _____

Medicare Part C (Medicare + Choice) Effective Date: _____

VI. CURRENT AND PREVIOUS COVERAGE

The information you provide about your other individual or group medical coverage (either prior or current) is necessary to determine whether you will have any waiting periods for preexisting conditions under the group health insurance plan under which you are applying for coverage. Your information will also help the small employer insurer(s) to coordinate benefits with any other group health coverage you may have. By providing this information you are not reducing your group health insurance for which you are applying.

Do you, your spouse or your dependent child(ren) listed in this application have current health insurance coverage or had previous health insurance coverage within the last 18 months? [ ] Yes [ ] No

If yes, please complete the following table and attach a copy of the Certificates of Creditable Coverage for each person.

Starting with you, the employee, identify each person applying for insurance and include information for all current and previous health insurance coverage(s) in effect during the last 18 months.

Name	Insurance Company, Plan & Group Number	Effective Date of Coverage (mo/day/yr)	Termination Date of Coverage (mo/day/yr)	Reason for Termination of Coverage	Type of Coverage (see key below)

Type of Coverage Key: **G** = Group Comprehensive Major Medical; **I** = Individual Comprehensive Major Medical; **M** = Medicare Supplement; **D** = Drug Coverage Only; **H** = Hospital Coverage Only; **V** = Vision Coverage Only

VII. MEDICAL INFORMATION

Please answer the following questions to the best of your knowledge. On the next page, please provide the complete details if you answer "yes" to any of the questions below. The date that this application is signed is the date from which you should use when answering questions that request you to provide prior history for various periods of time. **You are required to promptly notify your employer so that you may provide updated information to the small employer insurer(s) of any changes or developments in your, your spouse or your dependent child(ren)'s health history that occur prior to your employer's notifying you that there has been an insurer's underwriting decision regarding this application.**

A. Are you, your spouse or any child(ren) (even if not listed on the application) currently pregnant or an expectant parent? (If yes, due date is _____) [ ] Yes [ ] No

B. Has anyone named in this application been treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? [ ] Yes [ ] No

C. Has anyone named in this application used tobacco or smokeless tobacco during the past 12 months? [ ] Yes [ ] No
If yes, provide information as requested regarding the product, duration and frequency of use in section H below.

D. In the past 5 years has anyone named in this application been evaluated or treated for alcoholism or chemical dependency; or joined any organization for alcoholism or chemical dependency; or used illegal drugs or been advised by a health care professional to reduce the use of alcohol or illegal drugs? [ ] Yes [ ] No

E. Within the past 10 years, has anyone named in this application been counseled, consulted or treated for any of the following (*please check all conditions that apply*):

1. CIRCULATORY SYSTEM
- a) heart disease or disorder [ ] Yes [ ] No
- b) stroke [ ] Yes [ ] No
- c) circulatory disorder [ ] Yes [ ] No
- d) chest pain [ ] Yes [ ] No
- e) high or low blood pressure [ ] Yes [ ] No
- f) elevated cholesterol and/or triglyceride levels [ ] Yes [ ] No
- g) anemia or blood disorder [ ] Yes [ ] No

2. DIGESTIVE SYSTEM
- a) ulcers [ ] Yes [ ] No
- b) stomach disorder [ ] Yes [ ] No
- c) liver/pancreas disorder [ ] Yes [ ] No
- d) gallbladder disorder [ ] Yes [ ] No
- e) intestinal disorder (e.g., colitis, Crohn's disease) [ ] Yes [ ] No
- f) hernia [ ] Yes [ ] No
- g) rectal disorder [ ] Yes [ ] No

3. GENITOURINARY SYSTEM
- a) menstrual disorder [ ] Yes [ ] No
- b) genital disorder [ ] Yes [ ] No
- c) sexual dysfunction [ ] Yes [ ] No
- d) pregnancy complications (e.g., premature birth, miscarriage, c-section) [ ] Yes [ ] No
- e) infertility [ ] Yes [ ] No
- f) urinary tract/kidney/bladder disorder [ ] Yes [ ] No
- g) prostate disorder [ ] Yes [ ] No

4. ENDOCRINE SYSTEM
- a) diabetes [ ] Yes [ ] No
- b) thyroid disorder [ ] Yes [ ] No
- c) adrenal disorder [ ] Yes [ ] No
- d) enlargement of the lymph-nodes [ ] Yes [ ] No
- e) connective tissue disorder [ ] Yes [ ] No

5. RESPIRATORY SYSTEM
- a) allergy(ies) [ ] Yes [ ] No
- b) asthma [ ] Yes [ ] No
- c) emphysema [ ] Yes [ ] No
- d) sinus or nasal disorder [ ] Yes [ ] No
- e) lung disease or disorder [ ] Yes [ ] No
- f) shortness of breath [ ] Yes [ ] No

6. MUSCULAR or SKELETAL
- a) arthritis [ ] Yes [ ] No
- b) fibromyalgia [ ] Yes [ ] No
- c) back disorder [ ] Yes [ ] No
- d) joint disorder [ ] Yes [ ] No
- e) musculoskeletal disorder [ ] Yes [ ] No
- f) skin disorder [ ] Yes [ ] No
- g) chronic fatigue syndrome [ ] Yes [ ] No

7. NERVOUS SYSTEM
- a) epilepsy or other seizures [ ] Yes [ ] No
- b) headaches [ ] Yes [ ] No
- c) multiple sclerosis [ ] Yes [ ] No

8. CANCER
- a) cancer [ ] Yes [ ] No
- b) tumor [ ] Yes [ ] No
- c) abnormal growth [ ] Yes [ ] No
- d) carcinoma in situ [ ] Yes [ ] No

9. EAR OR EYE
- a) eye disorder [ ] Yes [ ] No
- b) ear disorder [ ] Yes [ ] No

10. BEHAVIORAL HEALTH
- a) attention deficit disorder [ ] Yes [ ] No
- b) psychological disorder [ ] Yes [ ] No
- c) suicide attempt [ ] Yes [ ] No
- d) eating disorder [ ] Yes [ ] No

11. OTHER
- a) organ or other type of transplant or implant [ ] Yes [ ] No
- b) breast disorder [ ] Yes [ ] No
- c) lupus [ ] Yes [ ] No

F. Within the last 5 years, has anyone named in this application to be covered by this insurance had any other injury, illness or treatment for any condition not already listed; been hospitalized or been scheduled for hospitalization; had surgery or had surgery scheduled; had a test or a test scheduled; or been recommended to have a test or surgery which was not performed for any reason not already mentioned in this application?
*We are **not** seeking the results of HIV Antibody test.* [ ] Yes [ ] No

G. In the space on the next page, please list and provide the complete details if you answered "yes" above to any of the questions or conditions contained in sections *A through F*. If you need additional space, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet).

Question Number	Name of Person	Dates of Treatment	Give full details for each question answered "Yes," state the condition, duration and degree of recovery	Name and address of attending physician or other health care provider

H. If anyone named in this application is taking medication or has had prescribed or recommended any medication during the period of time related to your answer (i.e. past 5 years, past 10 years, or currently taking), please list all those medications, dosages, and what medical condition is being treated or were treated by each medication in the space provided below. (Attach additional pages as needed and sign the additional pages.)

Name of Person	Name, dosage and frequency of medication (*include illness or health condition for which medication was prescribed*)	Date(s) medication taken (*indicate if ongoing*)	Name and address of prescribing physician or licensed health care provider and dispensing pharmacy

VIII. HEALTH PROVIDER OR PRODUCT SELECTION, IF APPLICABLE

This section should be completed only if the small employer group insurance for which you are applying requires the selection of a network, primary care provider or clinic. If applicable, it should also be used to select the product options offered by the employer or insurer. With respect to the provider or network selection, a selection should be made for each individual applying for such coverage and for each insurer from which insurance coverage is being sought. The provider numbers may be listed in the provider materials (i.e., directory) that are supplied by each insurer to your employer. The provider numbers for the same provider may not be the same for different insurers or products. Use additional sheets if necessary.

Insurer: ____

Product Type: ____

Coinsurance Option: _____________ Deductible Option: _____________ Copayment Option: _____________

Selected Provider is for (choose only one): [ ] Health Insurance [ ] Dental Insurance [ ] Other _______________

Covered Person's Name	Network or Provider's Name or Number	Is this your current provider?

Insurer: ____

Product Type: ____

Coinsurance Option: _____________ Deductible Option: _____________ Copayment Option: _____________

Selected Provider is for (choose only one): [ ] Health Insurance [ ] Dental Insurance [ ] Other _______________

Covered Person's Name	Network or Provider's Name or Number	Is this your current provider?

Insurer: ____

Product Type: ____

Coinsurance Option: _____________ Deductible Option: _____________ Copayment Option: _____________

Selected Provider is for (choose only one): [ ] Health Insurance [ ] Dental Insurance [ ] Other _______________

Covered Person's Name	Network or Provider's Name or Number	Is this your current provider?

IX. NON-HEALTH INSURANCE COVERAGE SELECTION, IF APPLICABLE

Availability of coverage is determined by your employer and whether the coverage is approved for issuance by the insurer(s).

Please list the insurer(s) below from whom you are applying for coverage and check all benefits for which you are applying.

If you have been given a choice of plans to apply for, or if the coverage you are applying for requires the selection of a primary care provider/clinic/network, please complete the section entitled "Provider and/or Product Selection."

If you are waiving application for any coverage on yourself and/or your spouse and/or dependent child(ren), please complete the "Waiver of Coverage" section at the end of this section.

A. GROUP DENTAL COVERAGE

[ ] Employee [ ] Employee and Spouse [ ] Employee and Dependent Child(ren)
[ ] Employee, Spouse and Dependent Child(ren)

Name of Insurer(s):
1. _____
2. _____
3. _____

Within the past 12 months, have you, your spouse or your dependent child(ren) had any individual or other group dental coverage? [ ] Yes [ ] No
If Yes, please provide the following information:
Orthodontia coverage? [ ] Yes [ ] No
Dental Insurer Name: _____ Policy Number: _____
Address: _____ Phone Number: _____
Coverage Effective Date: _____ Termination Date: _____
Is coverage still in effect? [ ] Yes [ ] No
Who was/is covered under the policy listed above? _____
Please attach copies of Certificates of Prior Coverage.

B. GROUP LIFE/AD&D COVERAGE (dependent coverage only available if employee coverage elected)

Name of Insurer(s):
1. _____
2. _____
3. _____

Employee Life/AD&D Amounts: Basic Issue $_____ Supplemental $_____ Optional $_____
Primary Beneficiary Name _____ Beneficiary's Social Security _____
Relationship of Beneficiary _____

Secondary Beneficiary Name _____ Beneficiary's Social Security _____
Relationship of Beneficiary _____

Dependent Life Amounts: Basic Issue $_____ Supplemental $_____ Optional $_____
[ ] Dependent Spouse Only [ ] Dependent Child(ren) Only [ ] Dependent Spouse and Dependent Child(ren)

C GROUP DISABILITY COVERAGE (only available to employees)

[ ] Short Term Disability [ ] Long Term Disability Your Annual Salary **$**_____

Name of Insurer(s):
1. _____
2. _____
3. _____

Basic Benefit Amount $_____/ per week **Optional Benefit Amount** $_____/ per week

D. GROUP DRUG COVERAGE

[ ] Employee [ ] Employee and Spouse [ ] Employee and Dependent Child(ren)
[ ] Employee, Spouse and Dependent Child(ren)

Name of Insurer(s):
1. _____
2. _____
3. _____

E. GROUP VISION COVERAGE

[ ] Employee [ ] Employee and Spouse [ ] Employee and Dependent Child(ren)
[ ] Employee, Spouse and Dependent Child(ren)

Name of Insurer(s):
1. _____
2. _____
3. _____

F. **WAIVER OF NON-HEALTH COVERAGE - This section must be completed if you or your dependents do <u>not</u> want the coverage listed above that is available to you through your employer.**

I understand that I am eligible to apply for coverage through my employer. I do NOT want coverage for (check all that apply):

Employee:	[ ] Dental [ ] Basic Disability	[ ] Basic Life/AD&D [ ] Optional Disability	[ ] Supplemental Life/AD&D [ ] Drug [ ] Vision	[ ] Optional Life
Spouse:	[ ] Dental [ ] Drug	[ ] Basic Life [ ] Vision	[ ] Supplemental Life	[ ] Optional Life
Dependent Child(ren):	[ ] Dental [ ] Drug	[ ] Basic Life [ ] Vision	[ ] Supplemental Life	[ ] Optional Life

The reason I am waiving group coverage at this time is because of:

[ ] Spousal coverage [ ] Individual Coverage [ ] Medicare [ ] Medical Assistance [ ] Other:

_____
_____
_____

WAIVER: I certify that I was not pressured, forced or unfairly induced by my employer, the agent, or the insurer(s) into waiving (declining) the above-noted coverage. I understand that in the event that I should decide to apply for such coverage at a later date, the application will be subject to the applicable terms and conditions of the employer's policy(s), which may require additional limitations and waiting periods. I also understand that I, my spouse and my dependent child(ren) may be required to furnish, at my own expense, evidence of health status/health history representation satisfactory to the insurer(s). I understand that the insurer(s) reserves the right to deny coverage with any future application for coverage.

Signature of Employee: _____ **Date Signed:** _____

Signature of Spouse: _____ **Date Signed:** _____

X. TERMS AND CONDITIONS

I hereby enroll for coverage under the insurance coverage(s) for which I am presently eligible, or for which I may become eligible under my employer's group contract(s). I have indicated in this Wisconsin Uniform Employee Application for Small Employer Group Health Insurance, if required, the Provider or Product Selection. I understand and agree that the information obtained by using this Application will be used by the insurer(s) to determine eligibility for benefits under my employer's group insurance policies. I, on behalf of myself, my spouse and my dependent child(ren), if any, named herein, agree to cooperate in providing the insurer(s) with information needed to process this Application. This might include signing a form for the release by hospitals, doctors, and other health care providers of pertinent heath care records to the Medical Information Bureau, the insurer(s) or their legal representatives.

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified in the space provided below the person(s) who provided me with such assistance. I declare and agree that the answers are, to the best of my knowledge and belief, complete and true and, together with any supplements or addendums thereto, shall be the basis for any certificate of coverage or certificate of insurance issued. I understand and agree that neither the employer nor the agent has the authority to waive a complete answer to any question, pass on insurability, alter any contract, or waive any of the insurer's other rights or requirements. I additionally agree that the insurer(s) is not liable for any statement, representation, or other information provided to me, my spouse or my dependent child(ren) that is not expressly contained in a written document provided to the insurer and signed by an authorized officer of the insurer. I agree that no insurance will be effective until the date specified by the company on the certificate of coverage or certificate of insurance after this application has been accepted. I understand that any misrepresentation contained herein and relied upon by the insurer may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of risk. I also understand that if I decline any coverage, future changes in coverage are NOT automatic and may be subject to the insurer's approval.

I understand and acknowledge that any person who, with intent to defraud or knowledge that the person is facilitating a fraud against an insurer, submits an application or files a claim containing a false deceptive statement is committing a fraudulent act that is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

If any payroll deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice to the employer. An enrollment form should not be submitted more than 30 days prior to the effective date. This document will become a part of the insurance contract when coverage is approved and issued.

I understand that I may request a copy of this Application and the Authorization to Use and Disclose Protected Health Information that are part of this Application. I agree that a photographic copy shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original.

Signature of Employee: _____ **Date Signed:** _____

Signature of Spouse: _____ **Date Signed:** _____

Signature of each listed dependent who has attained the age of 18:

_____ **Date Signed:** _____ **Print Name** _____

_____ **Date Signed:** _____ **Print Name** _____

Complete this section if someone assisted you in the completion of this Application.
The following person assisted me in completing the Application: _____
Please explain your relationship with him/her: _____

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Instructions: Please read this authorization form carefully before signing. This form must be signed by each adult person seeking coverage, including all adult dependent children. Parents should sign for their minor children unless the minor has received treatment without parental consent, consistent with state law. Your application cannot be processed without a signature for each person seeking coverage. Signing this form is a condition of coverage: if you decide not to sign, you will not be enrolled in a health plan of the insurers listed below. You have the right to receive a copy of this form following your signature.

I. Protected Health Information

By signing this form, I authorize certain organizations and persons to use or disclose my, my spouse's and my dependent child(ren)'s protected health information. Protected health information includes, but is not limited to, hospital records, physician records, lab results, mental health records, and alcohol and/or drug abuse records. Protected health information may be written, oral, or electronic. This form does **not** permit the use or disclosure of psychotherapy notes or the disclosure of information concerning whether I, my spouse or my dependent child(ren) have obtained a test for the presence of HIV antigen or nonantigenic products of HIV or an antibody to HIV or what the results of this test were.

II. Purpose of this Authorization Form

By signing this form, I, my spouse and my dependent child(ren) authorize the use and disclosure of protected health information for the purposes of pre-enrollment underwriting or risk-rating of health insurance coverage for me, my spouse and my dependent child(ren), to determine eligibility for enrollment or benefits under a health plan or to allow the insurer to conduct utilization review and quality improvement activities ("Purpose").

III. Entities Authorized to Use and Disclose My Protected Health Information

Insurers: I hereby authorize the following insurers, their reinsurers, and their legal representatives ("Insurers") to receive, use, and disclose my, my spouse and my dependent child(ren)'s protected health information for the Purpose listed above:

_____

_____

_____

I authorize the Insurers to disclose my, my spouse and my dependent child(ren)'s protected health information: between themselves, to reinsuring companies, and to the plan administrator (if other than the employer), plan sponsor (if other than the employer), insurance intermediaries, or other persons or organizations performing business or legal services in connection with the Purpose above.

I further authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc., consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me, my spouse or my dependent(s), to give to Insurers any and all protected health information about me, my spouse, or my dependent(s) to be covered concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal trait, and mode of living, including, but not limited to, all medical and health care records, but **not** including whether I, my spouse or my dependent(s) obtained a test for the presence of HIV antigen or nonantigenic products of HIV or what the results of this test were.

I, my spouse and my dependent child(ren) understand that protected health information described in this form may be used by, or disclosed to or by, organizations and persons who are not subject to federal or state privacy laws.

IV. Term of Authorization

I agree this Authorization shall be valid for two and one half (2 ½) years from the latest signature date below.

V. Right to Revoke

I understand I, my spouse or my dependent child(ren) may revoke this authorization at any time by giving advance written notice to Insurers. Revocation of this authorization form will not affect actions Insurers and others took in reliance on this form prior to the written notice of revocation.

I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THIS FORM. I UNDERSTAND THAT, BY SIGNING THIS FORM, I AUTHORIZE THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION DESCRIBED IN THIS FORM. I UNDERSTAND THAT I MAY ONLY REVOKE AUTHORIZATION FOR MYSELF OR MY MINOR CHILD(REN) UNLESS MY MINOR CHILD(REN) HAS RECEIVED TREATMENT WITHOUT MY CONSENT, CONSISTENT WITH STATE LAW.

Signature of Adult Applicant	**Date signed**	**Printed Name**
Signature of Spouse (if applicable)	**Date signed**	**Printed Name**
Signature of Adult Dependent (if applicable)	**Date signed**	**Printed Name**
Signature of Parent or Legal Guardian for Minor Child(ren) (if applicable)	**Date signed**	**Name of Minor Child** (please print)

If signing for more than one child, please list the names of each child for whom you are signing:

Name of Minor Child (please print)	**Name of Minor Child** (please print)
Name of Minor Child (please print)	**Name of Minor Child** (please print)

For services received by a minor that under state law the minor may consent to treatment without parental or legal guardian consent:

Signature of Parent or Legal Guardian for Minor Child (if minor received treatment with knowledge of parent)	**Date signed**	**Name of Minor Child** (please print)
Signature of Minor Child (if minor may have received treatment that does not require parent or legal guardian authorization)	**Date signed**	**Name of Minor Child** (please print)
Signature of Minor Child (if minor may have received treatment that does not require parent or legal guardian authorization)	**Date signed**	**Name of Minor Child** (please print)

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Jorge Gomez, Commissioner

Wisconsin.gov

Legal Unit
125 South Webster Street
Madison, Wisconsin 53702
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October 22, 2003

REPORT ON Section Ins 8.49, Wis. Adm. Code, relating to Small Employer Uniform Employee Health Application and Rule

Clearinghouse Rule No 03-055
Submitted Under s. 227.19 (3), Stats.
The proposed rule-making order is attached.

(a) Statement of need for the proposed rule

Sections 601.41(8) and 635.10, Wis. Stats., require the commissioner to promulgate rules and the uniform employee application form to be used when a small employer applies for coverage under a group health benefit plan offered by the small employer insurer. The rule and uniform application are currently in effect due to promulgation of an emergency rule. This submission is the permanent rule and final uniform small employer group health employee application.

(b) Modifications made in proposed rule based on testimony at public hearing:

Numerous modifications were made to the uniform application both after the rule hearing prior to the promulgation of the emergency rule and subsequent to the emergency rule the commissioner again reviewed comments received and modified both the rule and the uniform application. Changes to the rule include adding a section to clarify that small employer insurers and licensed intermediaries my pre-print the name of the small employer insurer on the uniform employee application provided that the form contains at least 3 additional spaces to insert the names of additional insurers to whom the uniform applications may be sent and the form otherwise complies with the rule. Changes to the uniform application range from the removal of shading to improve legibility of copies to addition of other types of group insurance employers might offer employees so that there is one form for the employees to complete.

(c) Persons who appeared or registered regarding the proposed rule:

Appearances For:
Ms. Laurie Kohls, Wis. Assn of Health Underwriters

Appearances Against:
Robert Wood, WPS Insurance Corporation
Karen Geiger, Cobalt Corporation
Pat Osborn, WALHI
Carol Rubin, WEA Insurance Corporation

Barbara Zabawa, Center for Public Representation

Appearances For Information:
Joe Kachelski, Wis. Assn of Health Plans

Registrations For:
Robert Lynn, Security Health Plan
Ramesh Kamath, Health-e-Transactions, LLC
Kamal Sham, Health-e-Transactions, LLC

Registrations Against:
Ron Hermes, HIAA
Christine Russell, WPS Insurance Corporation
Cathy Lang, Unity Health Insurance
Kathryn Ambelang, WPS Insurance Corporation
David Hill, Fortis Health

Registrations Neither for nor against:
Mary Haffenbredl, Atrium Health
Tom Springer, Golden Rule Insurance
Michael Polk, Group Health Cooperative-SCW
Bill Jensen, Group Health Cooperative-SCW
Carl Klein, Security Health Plan
Kelly Retan, The Management Group TMG
Joe Decker, Reinhart Boerner VanDeuren
Lori Desorcy, Touchpoint Health Plan
Jeffrey DesJardins, Touchpoint Health Plan

Letters received:
Letters received as part of the hearing record:

Exhibit 7: Karen Hanson, Principal Financial Group
Exhibit 8: Rep. Underheim, Sen. Leibham, & Rep. Grothman
Exhibit 9: Joe Kachelski, Wis. Assn. of Health Plans
Exhibit 10: Barbara Zabawa, Center for Public Representation
Exhibit 10A: Barbara Zabawa, Center for Public Representation
Exhibit 11: Carol Rubin, WEA Insurance Corporation
Exhibit 12: Pat Osborn, Wis. Assn. Life & Health Insurers
Exhibit 13: Karen Geiger, Cobalt Corporation
Exhibit 14: Marilyn Wagner, Golden Rule Ins. Co.
Exhibit 15: JP Wieske, American Medical Security
Exhibit 16: Kamal Shah, Health-e-Transactions
Exhibit 17: Robert Lynn, Registered Health Underwriter
Exhibit 18: Bill Smith, National Federation of Independent Businesses
Exhibit 19: Dan Schwartzer, Wis. Assn. of Health Underwriters.

Exhibit 20: Terrence Frett, Frett/Barrington
Exhibit 21: Christine Russell, WPS
Exhibit 22: Debra Manke, Genesis HealthCare USA

Letters received after implementation of emergency rule:
Rick Mason, Dean Health Plan
Shannon Ragan, Pacific Life
Carol Trocinski, United HealthCare
Katie Boycks, Wis. Assn. Life & Health Underwriters
Christine Russell, WPS
Dan Schwartzer, Wis. Assn. Health Underwriters
Mary Haffenbredl, Atrium HealthPlan
Diane Klenke, Ins. Agent
Noreen Parrett, LaFollette Godfrey & Kahn

(d) Response to Legislative Council staff recommendations

All comments were complied with and corrected except the following:
Section 2 Comment a: In accordance with s. 227.23, Wis. Stat., the uniform application is a form and need not be published in the code and register in its entirety, but may be listed by title or description together with a statement as to how it may be obtained. Section Ins 8.49(1), as proposed meets this requirement.
Section 5 Comment e: The sentence was modified but not exactly as recommended.
Section 5 Comment j: The sentence was modified but not exactly as recommended.
Section 5 Comment m & n: The waiver requirements parallel s. Ins. 8.60, Wis. Adm. Code. The Office does not regulate employers and therefore cannot require the employer to verify the employee's health insurance. It is the Office's belief that the vast majority of persons with significant health risk characteristics are aware and therefore, can reasonably respond to the inquiry.
Section 5 Comment r: This is a phrase routinely used in the industry and not overly confusing, therefore the Office did not modify.
Section 5 Comment v & w: This is phrasing routinely used in the industry and not overly confusing, therefore the Office did not modify.

(e) Regulatory flexibility analysis

1. The proposed rule does not impose any additional reporting requirements on small businesses. The rule does require small employers seeking group health insurance to utilize the form. The intent is to ultimately save small employers money by requiring less time of employees since the employees will now only need to complete one uniform application form, not multiple forms.
3. The proposed rule does not require any additional measures or investments by small businesses.

(f) Fiscal Effect

See fiscal estimate attached to proposed rule.

Enclosure: Legislative Council Staff Recommendations

849 Rule Legislative Report 1.Doc

LCRC
FORM 2

WISCONSIN LEGISLATIVE COUNCIL
RULES CLEARINGHOUSE

Ronald Sklansky
Clearinghouse Director

Richard Sweet
Clearinghouse Assistant Director

Terry C. Anderson
Legislative Council Director

Laura D. Rose
Legislative Council Deputy Director

CLEARINGHOUSE REPORT TO AGENCY

[THIS REPORT HAS BEEN PREPARED PURSUANT TO S. 227.15, STATS. THIS IS A REPORT ON A RULE AS ORIGINALLY PROPOSED BY THE AGENCY; THE REPORT MAY NOT REFLECT THE FINAL CONTENT OF THE RULE IN FINAL DRAFT FORM AS IT WILL BE SUBMITTED TO THE LEGISLATURE. THIS REPORT CONSTITUTES A REVIEW OF, BUT NOT APPROVAL OR DISAPPROVAL OF, THE SUBSTANTIVE CONTENT AND TECHNICAL ACCURACY OF THE RULE.]

CLEARINGHOUSE RULE **03-055**

AN ORDER to create Ins 8.49, relating to the small employer uniform employee application.

Submitted by **INSURANCE COMMISSIONER**

06-13-2003 RECEIVED BY LEGISLATIVE COUNCIL.

07-07-2003 REPORT SENT TO AGENCY.

RS:JLK

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LEGISLATIVE COUNCIL RULES CLEARINGHOUSE REPORT

This rule has been reviewed by the Rules Clearinghouse. Based on that review, comments are reported as noted below:

1. STATUTORY AUTHORITY [s. 227.15 (2) (a)]

   Comment Attached YES ☑ NO ☐

2. FORM, STYLE AND PLACEMENT IN ADMINISTRATIVE CODE [s. 227.15 (2) (c)]

   Comment Attached YES ☑ NO ☐

3. CONFLICT WITH OR DUPLICATION OF EXISTING RULES [s. 227.15 (2) (d)]

   Comment Attached YES ☑ NO ☐

4. ADEQUACY OF REFERENCES TO RELATED STATUTES, RULES AND FORMS [s. 227.15 (2) (e)]

   Comment Attached YES ☐ NO ☑

5. CLARITY, GRAMMAR, PUNCTUATION AND USE OF PLAIN LANGUAGE [s. 227.15 (2) (f)]

   Comment Attached YES ☑ NO ☐

6. POTENTIAL CONFLICTS WITH, AND COMPARABILITY TO, RELATED FEDERAL REGULATIONS [s. 227.15 (2) (g)]

   Comment Attached YES ☐ NO ☑

7. COMPLIANCE WITH PERMIT ACTION DEADLINE REQUIREMENTS [s. 227.15 (2) (h)]

   Comment Attached YES ☐ NO ☑

WISCONSIN LEGISLATIVE COUNCIL
RULES CLEARINGHOUSE

Ronald Sklansky
Clearinghouse Director

Terry C. Anderson
Legislative Council Director

Richard Sweet
Clearinghouse Assistant Director

Laura D. Rose
Legislative Council Deputy Director

CLEARINGHOUSE RULE 03-055

Comments

[NOTE: All citations to "Manual" in the comments below are to the Administrative Rules Procedures Manual, prepared by the Revisor of Statutes Bureau and the Legislative Council Staff, dated October 2002.]

1. Statutory Authority

a. According to s. 227.15 (1), Stats., an agency may not hold a public hearing on a proposed rule until after it has received a written report from the Legislative Council Rules Clearinghouse. The Office of Commissioner of Insurance (OCI) has scheduled a public hearing on July 11, 2003, which is before the statutory deadline for completion of the Clearinghouse Report. As a courtesy to OCI, the Rules Clearinghouse has expedited review of the rule and completed its report early so that the hearing may proceed as scheduled. In the future, please contact the Clearinghouse Director if OCI intends to schedule a public hearing prior to the date a Clearinghouse Report is due.

b. Section 635.10, Stats., provides that small employer insurers must use the uniform employee application form beginning no later than August 1, 2003. Section Ins 8.49 (1) (a) indicates that small employer insurers must use the form that is available beginning August 1, 2003, no later than the effective date of the rule. The effective date is stated in SECTION 2 as being the first day of the third month following publication.

First, given the public hearing process, the required submission of the proposed rule to the Legislature for committee review, and the subsequent submission to the Revisor of Statutes for publication, it seems extremely unlikely that the form will be available on August 1, 2003 as indicated in s. Ins 8.49 and in the analysis. Including this inaccurate date, or any date, in s. Ins 8.49 (1) (a) is not essential. It would appear to be advisable to simply indicate in s. Ins 8.49 (1)

(a) that small employer insurers must use the small employer uniform employee application form. (Also see Comment 2. a., below, for additional material to be inserted in s. Ins 8.49 (1) (a), further identifying the form.)

Second, there does not appear to be statutory authority to delay the effective date. As a practical matter, small employer insurers cannot use the form until it is published and they have had an adequate opportunity to convert their systems. While OCI may choose not to enforce the rule until insurers have had this opportunity, there does not appear to be statutory authority to delay the effective date beyond the first day of the month following publication.

c. Section Ins 8.49 (4) (a) requires a small employer insurer to state a premium within five business days from receipt of all pertinent information. Section 635.18 (6), Stats., permits a small employer insurer to deny an application, rather than providing a premium quotation. It appears that this alternative should be included, along with a requirement that the denial be in writing and state the reasons.

2. Form, Style and Placement in Administrative Code

a. Sections 601.41 (8) (b) and 635.10, Stats., require OCI to develop a small employer uniform employee application form by rule. This means that the content of the form should be included in the administrative code. This also means that future changes to the form are subject to rule-making. The form should be included as an appendix to ch. Ins 8 or as a subsection in s. Ins 8.49. A cross-reference to whichever method is selected should be included in s. Ins 8.49 (1) (a) to identify the form. Nonetheless, it is not inappropriate to include the note following s. Ins 8.49 (1) indicating where a copy of the form may be obtained and giving the web address for individuals who wish to download it. In addition, the note should specify that the form may be obtained "at no charge." [See s. 1.09 (2), Manual.]

b. The application form is replete with slashed alternatives. These create ambiguity and should not be used. [See s. 1.01 (9), Manual.] For example, in the fifth reason for waiver under Section II. of the application form, the reference to "and/or" should be changed to the appropriate conjunction because it is unclear if what is intended is that the total premium contribution for the employee plus spouse plus children would exceed 10% of earnings or if the premium contribution for each should be separately compared to 10% of gross earnings. The entire application form, including the two authorizations, should be reviewed for the use of slashed alternatives, and appropriate corrections should be made.

c. In Section VIII. of the application form, the first sentence of the third paragraph uses the slashed alternative "he/she." This should be changed to "the person". [See s. 1.01 (3), Manual.] A similar comment refers to the last line of the application form.

3. Conflict With or Duplication of Existing Rules

a. Section Ins 8.60 (1) prohibits a small employer insurer from issuing a policy unless all eligible employees and dependents are covered, unless coverage is declined by an employee

for certain reasons. One of those reasons is set forth in s. Ins 8.60 (1) (a) and is a declination because the individual has other coverage--if the small employer insurer determines that the other coverage provides benefits similar to or exceeding benefits provided under the basic health plan. It does not appear that the first, third, and fourth reasons for waiver under Section II. of the application form require that information about the other coverage be submitted in order to make the comparison of coverage. Were these provisions intended to be consistent with s. Ins 8.60 (1) (a)? [See also ss. Ins 8.60 (2) and 8.65.]

b. In Section II. of the application form, it is not clear why coverage under the health insurance risk-sharing plan (HIRSP) is not included as a reason for waiver inasmuch as it is included in s. Ins 8.60 (1) (e). Was the omission intentional?

5. Clarity, Grammar, Punctuation and Use of Plain Language

a. In the second paragraph of the analysis, the semicolon should be changed to a colon. Also, "permits" should be changed to "to permit".

b. In the second sentence of the third paragraph of the analysis, "regulations establishes" should be changed to "regulations establish". Also, the structure of the third item listed should be changed to be consistent with the introductory clause. For example, it could be changed to "small employer insurers are required to share...". In addition, the comma following "and" should be deleted.

c. The last paragraph of the analysis refers to a 60-day grace period. Was this intended to reflect the rule's taking effect on the first day of the third month following publication? If so, this may not be exactly 60 days. (However, see Comment 1. b., above.)

d. The first sentence of s. Ins 8.49 (2) (a) is confusing. It may be clearer if it indicated that a small employer insurer must consider information in an application form to be current if the form is received by the small employer insurer within 30 days after the date the form was completed, unless the form has been superseded by a more recently completed form or unless the insurer accepts additional or modified information that has subsequently been submitted.

e. The last sentence of s. Ins 8.49 (2) (a) confusingly refers to "information than was contained." Also, the sentence seems cumbersome. It appears that it could be reworded simply to state: "A small employer insurer may accept and use information provided by an employee subsequent to the date the employee signed the application form if the employee is providing additional or modified information.".

f. In s. Ins 8.49 (2) (b) (intro.), "the small employer" should be changed to "a small employer". Also, "to complete" should be changed to "to submit" in order to avoid the suggestion that the employer completes the employee application forms. Also, "occur" should be changed to "occurs" for subject and verb agreement.

g. In s. Ins 8.49 (3) (a), small employer insurers are required to forward "photocopies" of applications after receiving a request to forward "a copy". Was the limitation to photocopies,

as opposed to electronic copies, intentional? Also, as this potentially may involve many pieces of paper, is the small employer insurer permitted to charge the employer for complying with the request? In the last sentence of s. Ins 8.49 (3) (a), the reference to "it" should be changed to "the insurer". Also, "has requested information be sent" should be changed to "has requested that information be sent".

h. In the first sentence of s. Ins 8.49 (3) (b), the phrase "If the small employer" should be changed to "If a small employer". Also, at the end of the first sentence, "each small employer insurer" should be changed to "each identified small employer insurer" to avoid the implication that all small employer insurers are to receive the application. Also, in the last sentence, it appears that "insurer's authorized representative" should be changed to "insurer's authorized intermediary" to be consistent with the prior sentence, or vice versa.

i. In s. Ins 8.49 (4) (a), it appears that the word "materials" is unnecessary.

j. Section Ins 8.49 (4) (b) requires small employer insurers to make a reasonable effort to obtain the required information described in s. Ins 8.49 (4) (a), that is, all pertinent information required for underwriting. Is this intended to require that small employer insurers make a reasonable effort to obtain any additional information required for underwriting that was not submitted with the employer's application? Also, should there be a requirement that the insurers make an effort to obtain the information promptly? If so, it appears that s. Ins 8.49 (4) (b) could be redrafted to something such as: "If the small employer's application for group health insurance, including the uniform employee applications submitted with it, are insufficient to make an underwriting decision, a small employer insurer shall make a reasonable effort to promptly obtain all additional information required to make an underwriting decision.".

k. On the uniform employee application form, the introductory section and the "ref" section at the top of the first page should refer to "Wis. Stats." rather than "Wis. Stat."

l. In Section I. 2. a. of the form, "county and state" could be changed to "county and state, or country" to deal with marriages that did not occur in the United States.

m. In Section II. of the form, the first, third, and fourth reasons for waiver are that the employee, spouse, or dependent children are covered or "will be covered" under another plan that is not sponsored by the employer. A requirement is included that the identification card for the other plan be attached. However, if the person "will be covered," rather than being presently covered, it is not clear how an identification card could be attached. If the reason for waiver is that the person "will be covered," it may be preferable to require that the employee attach a statement explaining the other coverage and when the other coverage will take effect.

n. In Section II. of the form, the second reason for waiver is a statement by the employee that the employee does not have a risk characteristic or other attribute that would be the sole cause for the small employer insurer to make a decision with respect to premiums or eligibility for a policy that is adverse to the small employer. While this may be permitted as a reason for declining coverage under s. Ins 8.60 (1) (c), it is not clear how an employee would have the requisite information to make this statement. Also, if it continues to apply, should it

pertain solely to the employee, or should it also more clearly apply to the employee's spouse and dependent children?

o. In Section II. of the form, the fourth reason for waiver refers to "our identification card for their plan." It appears that "our" should be changed to "your" or "the".

p. In Section II. of the form, the fifth reason for waiver indicates that the annualized premium contribution to be paid by the employee "on behalf of myself or my dependent spouse and/or child(ren) would exceed 10% of my annualized gross earnings." Because the application form is being completed to request information about premiums, it is not clear how the employee would know that the premium contribution would necessarily exceed 10% of earnings. Also, according to s. Ins 8.60 (1) (d), the phrase "from the small employer" should be added so that income from other employers or other sources is not considered.

q. In Section II. of the form, the next-to-last paragraph indicates that the person has declined to enroll in coverage "as indicated above." No alternative is given for waiver if the person declines enrollment for any other reason, for example, because the premium contribution would be 9% of the person's gross earnings and the employee does not want to make the contribution or because there are religious reasons for rejecting health insurance coverage. An employee may be able to waive coverage for other reasons, even though, according to s. Ins 8.60 (1) (intro.), such a waiver would preclude the insurer from issuing a policy. It appears that the form should provide a space for the employee to state other reasons for waiver.

In the third sentence of this paragraph, "nor" should be changed to "or". Also, to be consistent with s. Ins 8.64, the phrase "I was not pressured nor forced" could be changed to "I was not pressured, forced, or unfairly induced". Also in that sentence, "waiving/declining" should be changed to one or the other, but not both. [See s. 1.01 (9), Manual.]

r. In Section IV. (a) of the form, the first sentence refers to listing "all dependents, spouse, and child(ren) applying for insurance." It is not clear what "dependents" means in this sentence.

s. In Section IV. (b) of the form, should the question with respect to dependent children who are full-time students apply to those who are 18 years of age or older? Also, does a small employer insurer need to know if 50% of support is provided for a grandchild who is, for example, three years old and is not a full-time student? If so, this question would not solicit the information. If a child does not live with both natural or adoptive parents, for example, following a divorce, is it necessary to get information about the percent of support as, presumably, either parent could cover the child as a dependent? If it is necessary, why should it matter if a minor child is a full-time student? Also, the introductory language states: "If required by the insurer...". How would the person completing the application know if it is required by the insurer? It appears that, if it is retained, the last sentence should be rephrased "If not, for which dependents do you not provide at least 50% support?".

t. In Section V. of the form, a person can truthfully answer "No" to the first question if he or she has Medicare Part A only coverage because the conjunction is "and." Is this the

intended result? If not, it may be more appropriate to simply ask if the person is "covered by Medicare" without designating the parts under that first question.

u. In the last sentence of the introductory paragraph of Section VI. of the form, it would be less confusing and more grammatically correct to change the phrase "prior to your receipt from your employer's that there has been" to "prior to your employer's notifying you that there has been".

v. In Section VI. C. of the form, the phrase "tobacco or smokeless tobacco" should be changed to "tobacco, including smokeless tobacco,".

w. In Section VI. D. 1. of the form, the conjunction "or" following each semicolon should be deleted. In addition, a semicolon should be inserted immediately preceding the phrase "or been advised".

x. In Section VI. of the form, items D., E., and F. refer to either the "past" or "last" 10 years or 5 years. Is this 5 or 10 years from the exact date the form is completed or calendar years? It is assumed that it is the former, but consideration could be given to clarifying this.

y. In Section VI. E. of the form, the question mark following 1. (f) should be deleted. Also, the phrase "please check all that apply" in the introduction is unclear; when a person can check "yes" or "no" all of the choices apply.

z. In Section VI. F. of the form, the phrase "application to be covered by this insurance" could be changed to "application". This would be consistent with Section VI. E. and eliminate unnecessary wording.

aa. In Section VI. F. of the form, a space is provided after the question to list details of answers "yes" to questions A. through F. It would be less confusing if this were item G. This would necessitate renumbering a previous cross-reference and changing the subsequent section to item H. Also, it appears that the phrase "any of the" should be inserted before the phrase "questions A through F."

bb. Section VI. G. of the form specifies that if anyone named in the application "is taking, has had prescribed or recommended, medication" then information must be provided. The form does not make clear which time period the phrase "has had prescribed or recommended" applies to. This could be interpreted as applying to a medication taken at any time during the person's life. Is this the intended result? This should be clarified. Also, "or" should be inserted preceding "has".

cc. Section VII. of the form is to be completed only if the insurance requires the selection of a network, primary care provider, dentist, or clinic. The grid form to be completed suggests that if the choice is between various networks, each covered person in a family could select a different network. Is this the intention?

dd. In Section VIII. of the form, the fifth sentence of the second paragraph refers to "other information provided to myself". The word "myself" should be changed to "me". Also in

that sentence, it is not clear who "them" refers to in the phrase "written document provided to them".

ee. The following comments apply to the "AUTHORIZATION TO OBTAIN MEDICAL INFORMATION" form:

(1) In the first sentence of the first paragraph, it appears that "knowledge of me, my spouse, or my minor or dependent children's health and health care" should be changed to "knowledge of my, my spouse's, or my minor or dependent children's health and health care". Otherwise, the form authorizes any organization or institution to release any record or "knowledge" about an employee and the employee's spouse, not just health and health care records. Unless that result was intended, this should be amended.

(2) The first paragraph indicates that "psychotherapy notes" are excluded from the authorization to release health or health care records. However, the second paragraph further authorizes the release of information or records pertaining to "mental illness diagnosis or treatment," and "psychotherapy notes" are not excluded in the second paragraph. Since there is a separate form for authorization to disclose psychotherapy notes, it appears that psychotherapy notes should also be excluded from the second paragraph.

(3) It appears that the last sentence of the first paragraph should be changed to state that "The Companies to which information may be released are:". Otherwise, the "includes" language could be interpreted as not limiting disclosure to the specified companies and would result in an inconsistency with s. Ins 8.49 (3) (b).

(4) In the second paragraph, "organization, institution that" should be changed to "organization, or institution that".

(5) In the third paragraph, "by the Company, or to" should be changed to "by the Company to."

(6) In the third paragraph, does the exception that permits providing information to the "plan sponsor" mean, for example, that records about a person's diseases, alcoholism, or mental illness could be disclosed to the individual's employer? Is there any prohibition on redisclosure if records are authorized to be released under the third paragraph?

(7) The first few sentences of the fifth paragraph refer to "I" and "my." However, the last two sentences refer to "you" and "your" as if the signator were being addressed in the second person instead of actually being the first person. This inconsistency is confusing and should be remedied.

(8) This authorization is to be signed by the applicant and the applicant's spouse. It is not clear that this authorization is valid for disclosure of information about a dependent child who is not a minor.

ff. The following comments apply to the "AUTHORIZATION PSYCHOTHERAPY NOTES" form:

(1) It appears that the form should be titled "AUTHORIZATION TO OBTAIN PSYCHOTHERAPY NOTES" since that is the stated title of the form in the fifth paragraph.

(2) In the first paragraph, "knowledge of me, my spouse, or my minor or dependent children's psychotherapy notes or information" should be changed to "knowledge of my, my spouse's, or my minor or dependent children's psychotherapy notes or information". (See Comment ee. (1), above.)

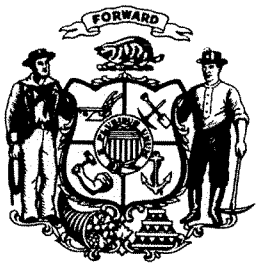
(3) In the first paragraph, "authorize any licensed physician...may release" should be changed to "authorize any licensed physician...to release".

(4) In the second paragraph, the comma should be deleted in the phrase "by the Company, to any person".

(5) In the second paragraph, does the exception that permits providing information to the "plan sponsor" mean that psychotherapy notes could be disclosed to the individual's employer? Also, is there any prohibition on their redisclosure if records are authorized to be released under the second paragraph?

(6) In the fourth paragraph, the last two sentences switch from the first person to the second person "you" or "your." This inconsistency should be remedied.

(7) This authorization includes a signature line for a "Minor or Dependent Child, (if treatment was received without parental consent, in accordance with state law)". First, the comma should be deleted. Second, is it possible that some states require the signature of a minor or dependent child even if the treatment were received with parental consent? Also, does "dependent child" mean a child who is age 18 or over, or does it have some other meaning? This should be clarified.



Senate Committee on Agriculture, Financial Institutions and Insurance

Room 18 South State Capitol, PO Box 7882, Madison WI 53707-7882
(608) 266-0703

Senator Dale W. Schultz, Chairman

Committee Clerk. John O'Brien

July 26, 2004

Lorrie Keating Heinemann, Secretary
Wisconsin Department of Financial Institutions
345 W. Washington Ave.
5th Floor
Madison, WI 53703

Re: CR 04-041

Dear Secretary Heinemann,

This letter is to inform you that during today's public hearing, the Senate Committee on Agriculture, Financial Institutions and Insurance took Executive Action on Clearinghouse Rule 04-041, relating to authorization to collect a returned check fee.

On a unanimous vote, the committee objected to CR 04-014 on a motion that the rule was. "Arbitrary and capricious as well as imposing an undue hardship on small business." The motion included an objection to the Department of Financial Institutions failure to conduct the required Small Business Impact Study.

If you have questions related to the committee's action, feel free to contact the committee clerk.

Thank you,

Dale W. Schultz, Chairman