Chapter Ins 8

EMPLOYE WELFARE FUNDS; EMPLOYE BENEFIT PLAN ADMINISTRATORS; SMALL EMPLOYER HEALTH INSURANCE

Note: Sections Ins 8.20 to 8.32 were created as emergency rules effective October, 1, 1991. Sections Ins 8.40 to 8.56 were created as emergency rules effective February 12, 1992.

Ins 8.01 Receipt of payments from funds by parties-in-interest. (1) Section 641.19 (2), Stats., prohibits certain persons who are or may be in a position to influence the operations of an employe welfare fund from engaging in certain transactions with such fund or which affect such fund directly or indirectly. The parties to whom the prohibition is directed are the trustees of the fund, the participating employers, the labor organizations representing any employes covered by the fund, and the officers, agents and employes of such trustees, employers and labor organizations. One of the prohibitions placed upon such parties is the receipt of any payment, commission, loan, service or any other thing of value from the fund or which is charged against the fund or would otherwise be payable to the fund, either directly or indirectly. This prohibition does not extend to the receipt of benefits from the fund by any such party who is entitled thereto under the plan nor does the statute prohibit a trustee or officer, agent or employe from receiving from the fund reasonable com-

pensation for necessary services and expenses rendered or incurred in connection with official duties in respect to the fund.

(2) The prohibition applied to receipts by the specified parties from the fund. The penalties for engaging in a transaction prohibited by s. 641.19 (2), Stats., would be enforceable against the persons named therein rather than against the fund. Accordingly it may be said that s. 641.19 (2), Stats., does not govern investments by a fund but rather governs the specified parties in their dealings with a fund.

(3) The law does not prohibit the trustees of a fund from investing fund monies in any certain way but it does prohibit trustees and other specified persons who may be in a position to influence the transactions of a fund from using their positions to enrich themselves at the expense of a fund either directly or indirectly. At the same time, the law does not alter the duty of trustees clearly established in other laws, both statutory and common, to manage funds exclusively for the purpose of providing the employe benefit promised.

(4) At the time of the enactment of this law, transactions between funds and participating employers, employes and labor organizations were an established practice. The internal revenue code of the United States recognizes that many such transactions may be entered into without impairing the tax status of such funds. Many of the trust agreements under which such funds are established and maintained specifically authorize the trustees to engage in such transactions on behalf of the funds. We do not interpret the law to prohibit all such transactions. What is prohibited is the receipt by any specified party of a payment, commission, loan, service or any other thing of value from a fund under such circumstances that at least an equivalent value in money's worth is not received by the fund from such person as a part of such transaction.

Note: In the following examples the receipt of a valuable consideration by the party as specified would not appear to be prohibited in the stated circumstances. These examples are not intended to be all-inclusive.

1. Receipt from a fund by a participating employer or labor organization of reasonable compensation for the fair value of necessary services rendered to the fund or for the actual cost of necessary expenses incurred for or on behalf of the fund.

2. Receipt from a fund by a participating employer or labor organization of payment for necessary real property or equipment sold or leased to the fund for use in the operations of the fund in an amount not in excess of the fair market value of such property or equipment at the date of sale or the fair rental value at the date of lease. Any facts known to such an employer or labor organization which would influence such market or rental value must necessarily be considered in determining the fair value at such date.

3. Purchase or lease of real estate or equipment from a fund by a participating employer or labor organization if such purchase or lease is made at arms-length on such terms and conditions as would be required at such time by an independent financial institution or other business organization engaged in such transactions which has knowledge of all facts pertinent thereto which are known by such employer or labor organization. If the terms and conditions required by such organizations cannot be established, the terms and conditions should be equivalent to those which would be granted by any independent vendor or lessor having knowledge of all pertinent facts known to such employer or labor organization and considering both the probable income and probable safety of his or her capital.

4. Receipt by a participating employer or labor organization of a loan from a fund if such loan is made at arms-length according to such terms and conditions, including the rate of interest and duration of the loan and the nature and amount of security pledged therefor, as would be required at such time by an independent financial institution or other business organization engaged in making such loans which has knowledge of all facts pertinent thereto which are known by such employer or labor organization.

5. Receipt by a participating employe of a loan from a fund if such loan would meet the requirements of a loan to a participating employer or labor organization as specified in example 4. above.

6. Purchase of securities or other investments from a fund by a participating employer or labor organization if made for not less than an adequate consideration to the fund. An "adequate consideration" means the price which would be paid at such time by an independent buyer having knowledge of all facts pertinent thereto which are known to such employer or labor organization. Such value may be established by an impartial appraisal of the investment if such value cannot be established by reference to bid and asked prices or by reference to sales prices.

7. Sale of securities or other investments to a fund by a participating employer or labor organization if made for not more than an adequate consideration as defined by example 6. above.

8. Purchase from or sale to a fund by a participating employer of its capital stock if in accord with conditions described in examples 6. and 7. above.

History: Cr. Register, August, 1960, No. 56, eff. 9-1-60; am. (1) and (2), Register, November, 1978, No. 275, eff. 12-1-78; corrections made under s. 13.93 (2m) (b) 5., Stats., Register, April, 1992, No. 436.

Ins 8.02 "Trust fund or other fund", definition. (1) A "trust fund or other fund" constituting an employe welfare fund subject to ch. 641,

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administered by the administrator and to any such employe benefit plan on behalf of the residents of this state who are its beneficiaries in the event of injury caused by a failure of the administrator to fulfill its responsibilities as an administrator.

(2) If the administrator collects premiums or employe contributions on behalf of any principal, or commingles funds belonging to more than one principal, the performance bond shall be in the greater of the following amounts:

(a) $25,000.

(b) Ten percent of the total amount of projected premiums, charges and claim funds the administrator expects to handle on behalf of residents of this state during the fiscal year following the year for which a financial statement is submitted under s. Ins 8.26 (1) (c). A bond under this paragraph need not exceed $500,000.

(3) If the administrator does not collect premiums or employe contributions on behalf of any principal, and maintains a separate fiduciary account for each principal, the performance bond shall be in the greater of the following amounts:

(a) $15,000.

(b) Five percent of the total amount of projected claim funds the administrator expects to handle on behalf of residents of this state during the fiscal year following the year for which a financial statement is submitted under s. Ins 8.26 (1) (c). A bond under this paragraph need not exceed $250,000.

(4) An administrator may exclude from the calculations required under sub. (2) (b) or (3) (b) all amounts handled as administrator for any of the following:

(a) Self-insured, partially insured or divided insurance worker's compensation plans subject to s. Ind 80.60 or 80.61.

(b) Warranty plans subject to ch. Ins 15.

Note: Notwithstanding s. Ins 8.28, as created by an emergency rule effective October 1, 1991, a bond meeting the requirements of s. Ins 8.28, effective May 1, 1992, shall satisfy the bond requirements for an administrator required to submit an initial license application before May 1, 1992.

History: Cr. Register, April, 1992, No. 436, eff. 5-1-92.

Ins 8.30 Notification to office. An administrator shall notify the office in writing of any of the following within 30 days after the date of the occurrence:

(1) The cessation of business activities as an administrator. A notification under this subsection shall include the name and address of the custodian of the administrator's business records and the location of those records.

(2) Any change in the administrator's business mailing address or the location of its business records.

(3) Formal administrative action in this state or another state by an agency that regulates the business of administrators, insurance, real estate, securities or financial institutions against the administrator or any

officer, director, partner or other individual having comparable responsibilities in the corporation or partnership.

(4) The conviction in this state or another state of a felony or misdemeanor, other than a misdemeanor related to the use of a motor vehicle or the violation of a fish and game regulation, of the administrator or any of the officers, directors, partners or other persons having comparable responsibilities in the corporation or partnership.

History: Cr. Register, April, 1992, No. 436, eff. 5-1-92.

Ins 8.32 Audit. In order to determine whether the financial resources of an administrator are adequate to safeguard the interests of the public and persons covered by a plan, or to determine the appropriate bond amount under s. Ins 8.28, the office may order the administrator to submit financial statements that have been audited by a certified public accountant.

History: Cr. Register, April, 1992, No. 436, eff. 5-1-92.

Subchapter III — Small Employer Health Insurance

Ins 8.40 Purpose. This subchapter interprets and implements subch. I of ch. 635, Stats.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92.

Ins 8.42 Definitions. In addition to the definitions in s. 635.02, Stats., which apply to this subchapter, in this subchapter:

(1) "Commissioner" means the commissioner of insurance.

(2) "Office"means the office of the commissioner.

(3) "Policy" means any of the following:

(a) A group health benefit plan issued to a small employer.

(b) An individual health benefit plan issued by a small employer insurer to 3 or more employes of the same small employer, where premium is collected through a direct or indirect arrangement with the small employer.

(c) In the case of a health benefit plan that provides coverage for more than one employer through a trust or association, the certificate issued to an individual small employer.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92.

Ins 8.44 Applicability; exclusion. (1) Subchapter I of ch. 635, Stats., and this subchapter apply to a policy issued to a small employer if the number of eligible employes in this state was not less than 2 nor more than 25 during at least 50% of the number of weeks the small employer was actively engaged in the business enterprise during the 12 months preceding the date of application or the policy renewal date.

(2) In addition to the types of policies excluded under s. 635.02 (3m), subch. I of ch. 635, Stats., and this subchapter do not apply to policies providing only specified disease coverage or to hospital indemnity policies, as defined in s. 632.895 (1) (c), Stats.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92.

Ins 8.46 Required policy provisions. Each policy shall include all of the following:

(1) On the face page or first page, a statement that the policy is guaranteed renewable except for the reasons stated in the policy, which shall be consistent with s. 635.07 (1) and (2), Stats.

(2) A statement of the minimum number of eligible employes required in order to keep the policy in effect, expressed either as an absolute number or as a percentage of eligible employes or both. The method for determining the minimum number required shall be stated in the policy or employer agreement. For purposes of this subsection, "eligible employe" does not include any person who has continued coverage under s. 632.897 (2) (b) 2, Stats., under a small employer's group policy.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92.

Ins 8.48 Solicitation; disclosure requirements. (1) AGENTS. Before completing an application for a policy, an agent shall provide the small employer or representative of the small employer or the individual applicant with a form stating the information required under s. 635.11 (1) to (4), Stats. The agent shall sign and date the form certifying that he or she made the required disclosure and shall obtain the signature of the small employer or representative of the small employer or the individual applicant on the form. The agent shall give one copy of the completed form to the person who signed it. The agent or small employer insurer shall retain one copy of the completed form.

(2) SMALL EMPLOYER INSURERS. A small employer insurer that does not use agents to solicit or sell policies shall, with any solicitation material, provide the small employer or individual applicant with a form stating the information required under s. 635.11 (1) to (4), Stats. The small employer insurer shall secure with or as part of each application a form signed by the small employer, a representative of the small employer or individual applicant stating that he or she has received the information. The small employer insurer shall provide a copy to the person who signed the form no later than the date the policy is issued.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92.

Ins 8.50 Underwriting restriction. In determining whether to issue or continue to provide coverage to a small employer, a small employer insurer may not consider the occupation of the employes of the small employer or the type of business in which the small employer is engaged.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92.

Ins 8.52 Regulation of rates and rate changes. (1) IDENTIFICATION OF THE SET OF MIDPOINT RATES. (a) Each small employer insurer shall identify a set of rates applicable to all combinations of case characteristics and benefit design characteristics that serves as the set of midpoint rates for policies issued to small employers. These rates shall be represented by any combination of rates and rating factors that satisfy the following:

1. All differences among rates in the set shall be in accordance with the insurer's rate manual or rating procedures and shall be based on the actuarially determined values of the differences in case characteristics and benefit design characteristics.

2. The differences among the rates may not reflect any differences due to such factors as the claim experience, health status and duration of coverage of an individual policy or a collection of policies grouped according to anything other than case characteristics or benefit design.

(b) The set of midpoint rates identified in par. (a) shall apply during a specified period which shall not be less than one calendar month.

(2) RATE VARIANCE RESTRICTION. (a) For a new policy issued on or after March 15, 1992, the following table lists the maximum percent a rate may vary from the midpoint rate applicable to policies with the same case characteristics and benefit design characteristics according to the effective date of any rate applied to that policy:

EFFECTIVE DATE OF RATE	MAXIMUM VARIANCE FROM MIDPOINT RATE
1. March 15, 1992 - August 14, 1994	35%
2. August 15, 1994 and after	30%

(b) For a policy issued before March 15, 1992, an insurer shall comply with the rate variance restriction specified in par. (a) 2 no later than August 15, 1994.

(3) PREMIUM RATE CHANGES; DOCUMENTATION AND RESTRICTIONS. (a) For the purpose of complying with s. 635.02 (2), Stats., and this subsection, "class of business" means a group of policies with the same or similar benefit design whose rates are based wholly or partly on their aggregate loss experience.

(b) For a policy renewed on or after March 15, 1993, an insurer shall maintain sufficient documentation so that each of the following distinct components can be identified:

1. The percentage change in the new business premium rate measured from the rating period in which the small employer was last rated to the current rating period or, in the case of a class of business for which the insurer is not issuing new policies, the corresponding change in the base premium rate.

2. The percentage change due to adjustments in case characteristics, determined in accordance with the insurer's rate manual or rating procedures.

3. The percentage change due to adjustments in benefit design, determined in accordance with the insurer's rate manual or rating procedures.

4. The percentage change due to such rating factors as claim experience, health status and duration of coverage, determined in accordance with the insurer's rate manual or rating procedures.

(c) Each renewal rate, regardless of whether the rate represents an increase, shall be limited to the previous rate adjusted by the combination of the 4 components specified in par. (b) with the following restrictions on the experience component specified in par. (b) 4:

1. For a policy issued on or after March 15, 1992, the experience component shall be limited to 15% per year, adjusted proportionately for rating periods of less than one year.

2. For a policy issued before March 15, 1992, subd. 1 applies, except if the premium rate exceeds the midpoint rate by more than the percentage specified in sub. (2) (a) for the applicable period for policies with the same case characteristics and benefit design characteristics, the experience component may not exceed 0%.

(d) For a rate change due to a change in the small employer's census made before the end of the policy term, par. (c) applies, except that:

1. The new business rate change component specified in par. (b) 1 may not be applied at that time.

2. The experience component specified in par. (b) 4 may not exceed 15% per year, adjusted proportionately to the time remaining in the policy term.

3. The experience component specified in par. (b) 4, when combined with the experience component of the last scheduled rate renewal and any other subsequent rate changes during the current policy term, shall not exceed the limit specified in par. (c) 1 or 2, whichever applies.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92.

Ins 8.54 Guaranteed renewability; cancellation and renewal restrictions. (1) DEFINITION. (a) In this section, "medically underwritten policy" means a policy that is issued after the small employer insurer has, for purposes of risk selection, used information about the group's claim experience or the health history or medical records of one or more persons eligible for coverage.

(b) Notwithstanding par. (a), a small employer insurer may apply medical underwriting standards to an individual who originally declined and later applies for coverage under a nonmedically underwritten policy without converting that policy to a medically underwritten policy.

(2) CLASS OF BUSINESS. (a) In this section, each of the following is a separate class of business, regardless of variations in policy forms, marketing methods or duration of coverage among small employers in the class of business:

1. All small employers with medically underwritten policies.

2. All small employers with policies that are not medically underwritten.

3. All small employers whose policies constitute a block of business assumed by the small employer insurer under a specific assumption treaty with an insurer that is not an affiliate.

(b) No small employer insurer may establish a class of business other than one specified in par. (a).

(3) GUARANTEED RENEWABILITY. Except as provided in s. 635.07, Stats., a policyholder has the right to renew a policy on the same terms subject to the premium rate restrictions specified in s. Ins 8.52 (3). The subsection does not prohibit a small employer insurer from offering a policyholder renewal with altered benefit design characteristics if the offer is available to all policyholders in the same class of business without regard to claim experience.

(4) TERMINATION. (a) A small employer insurer that intends to terminate a policy under s. 635.07 (1) (d), Stats., because the number of eligible employes is less than the number required to keep the policy in force shall do all of the following:

1. Notify the small employer of its intent to terminate and the reason for the termination. The notice shall be given at least 20 days before the termination date.

2. Offer to continue the small employer's coverage for not less than 60 days after the termination date in order to allow the small employer to increase the number of eligible employes to the required number.

3. Provide the additional coverage, if the small employer accepts the offer under subd. 2 before the termination date and pays the premium for the additional coverage at the rate in effect at the time the additional coverage is provided.

(b) A small employer insurer may not terminate a policy under s. 635.07 (1) (d), Stats., if the reason the number of eligible employes is less than the required number is due to an employe's sickness or injury, approved leave of absence or temporary layoff. The small employer insurer may establish participation requirements and reasonable verification procedures as part of the policy or employer agreement.

(c) A small employer insurer may not take into consideration factors related to an individual small employer's claim experience in deciding whether to terminate a policy under s. 635.07 (1) (d), Stats.

(d) A small employer insurer that intends to terminate a policy under s. 635.07 (1) (a) to (c) or (e), Stats., shall comply with the notice requirements under s. 631.36 (2) (b) and (c), (4), (6) and (7), Stats.

(5) NONRENEWAL OF CLASS OF BUSINESS. (a) If a small employer insurer ceases to renew policies issued to all small employers in the same class of business under s. 635.07 (2), Stats., the small employer insurer may not establish any new class of business during the 5-year period beginning with the latest expiration date for policies in effect in the class of business that is not renewed.

(b) At least one year before a small employer insurer ceases to renew policies under s. 635.07 (2), Stats., the small employer insurer shall provide the office with all of the following information:

1. The reason for the decision not to renew.

2. The number of small employers and the total number of eligible employes affected by the decision not to renew.

3. The number of small employers in other classes of the small employer insurer's business that are not affected by the decision not to renew.

(c) The commissioner may order an examination under s. 601.43, Stats., in order to determine the premium rate history and obtain information on the profitability of the nonrenewed class of business.

(d) At least one year before a small employer insurer ceases to renew policies under s. 635.07 (2), Stats., the small employer insurer shall provide written notice of that intent to all affected small employers and the

insurance regulatory agency in each state in which an affected insured individual resides. The notice shall include all of the following:

1. The reason for the decision to terminate coverage for the class of business.

2. The date on which coverage will terminate.

(e) In addition to the requirement under par. (d), the small employer insurer shall, at least 60 days but not more than 75 days before the date coverage will terminate, provide each affected small employer with written notice, complying with s. 631.36 (6) and (7), Stats., of the intent not to renew the policy. The notice shall also comply with the notice requirements of ss. 632.79 and 632.897, Stats.

(6) CONVERSION OF ASSUMED CLASS OF BUSINESS. A small employer insurer that assumes a class of business from another small employer insurer shall, by the 2nd renewal date for each policy or one year from the date of assumption, whichever is later, convert each policy in the assumed class of business to a policy with the same or similar benefit design characteristics in another class of business specified under sub. (2) (a).

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92.

Ins 8.56 Certification of compliance; additional information required. (1) The annual certification of compliance required under s. 635.13, Stats., shall be submitted in the form prescribed by the office.

(2) In addition to the annual certification required under sub. (1), the commissioner may require a small employer insurer to furnish additional information including, but not limited to, the following, using the form and method of transmittal prescribed by the commissioner:

(a) Rate manuals or exhibits of all rating factors used for each class of business.

(b) Sample data of small employers including premiums charged and rating factors applied for case characteristics and benefit design characteristics.

(c) An inventory of case characteristics used by the small employer insurer since the last certification date.

(d) An exhibit showing the difference in new business premium rates between the current certification date and the last certification date.

(e) A description of how midpoint rates are determined.

Note: The form required under sub. (1), OCI 26-051, may be obtained from the Office of the Commissioner of Insurance, P. O. Box 7873, Madison, WI 53707-7873.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92.

Subchapter IV — Basic Health Benefit Plan For Small Employers

Ins 8.70 Purpose. This subchapter implements subch. II of ch. 635, Stats., by establishing the basic health benefit plan that small employer insurers shall actively market and offer to small employers.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

Ins 8.71 Definitions. (1) The definitions in ss. 635.02 and 635.20, Stats., apply to this subchapter.

(2) In this subchapter, "health care provider" means any of the following:

(a) A medical or osteopathic physician, podiatrist, physical therapist or physician's assistant licensed or certified under ch. 448, Stats.

(b) A psychologist licensed under ch. 445, Stats.

(c) A chiropractor licensed under ch. 446, Stats.

(d) A nurse midwife certified under s. 441.15, Stats.

(e) A nurse practitioner licensed under ch. 441, Stats.

(f) A nurse licensed under ch. 441, Stats., who is certified as a nurse anesthetist by the American association of nurse anesthetists.

(g) A dentist licensed under ch. 447, Stats.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

Ins 8.72 Basic benefits. Subject to the limitations and restrictions under s. Ins 8.75 and copayments and coinsurance under s. Ins 8.77, each plan shall provide coverage for all of the following, if medically necessary:

(1) Professional services by a health care provider acting within the scope and limitations of his or her license or certificate or a person acting under the direction of a health care provider, including all of the following:

(a) Office, outpatient, inpatient and emergency room visits including treatment rendered during those visits.

(b) Surgical services including postoperative care following inpatient or outpatient surgery.

(c) Services of an assistant surgeon if necessary to perform surgery.

(d) Anesthesia services.

(2) Hospital care, including all of the following:

(a) Semi-private room, board and ancillary services and supplies that are generally provided to hospital inpatients.

(b) Confinement in an intensive care or coronary care unit of a hospital.

(c) Outpatient medical care and treatment.

(d) Medical care and treatment provided in a hospital emergency room.

(3) Medical care and treatment provided in an ambulatory surgery center, as defined in s. 49.45 (6r) (a) 1, Stats.

(4) Outpatient x-ray, laboratory and other diagnostic tests.

(5) Confinement in a skilled nursing home licensed under subch. I of ch. 50, Stats.

(6) Services provided by a home health agency licensed under s. 141.15, Stats.

(7) Care provided by a hospice licensed under subch. IV of ch. 50, Stats.

(8) Local ground licensed ambulance services.

(9) Physical therapy.

(10) Rental and purchase of durable medical equipment and supplies.

(11) Prescription drugs.

(12) Reconstructive surgery which is either of the following:

(a) Incidental to or following surgery necessitated by illness or injury.

(b) Caused by a congenital disease or anomaly of a covered dependent child which results in a functional defect.

(13) Sterilization.

(14) Maternity services including all of the following:

(a) Prenatal services normally associated with pregnancy.

(b) Delivery services normally associated with a vaginal or caesarean section delivery.

(c) Routine nursery care from the moment of birth until the infant is discharged from the hospital.

(15) Complications of pregnancy.

(16) Inpatient, outpatient and transitional treatment for nervous and mental disorders and alcoholism and other drug abuse, subject to s. Ins 8.75 (3).

(17) Preventive services appropriate to the age and sex of the covered person including all of the following:

(a) Routine physical examinations and health screening tests.

(b) Immunizations for poliomyelitis, diphtheria, pertussis, typhoid, measles, mumps and rubella.

(c) Vaccinations for hemophilus influenza, type B.

(d) Diphtheria and tetanus boosters.

(e) Influenza and pneumonia vaccinations.

(f) Tuberculosis skin tests.

(18) Organ transplants that are covered by medicare.

(19) Services provided by a dentist for the repair of accidental dental injuries.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

Ins 8.73 Health insurance mandates. A plan shall comply with the health insurance mandates, as defined in s. 601.423, Stats., and may not exclude or limit coverage for any mandate except as provided in s. Ins 8.75 (3).

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

Ins 8.74 Policy title; term. (1) The policy form for a plan submitted to the office of the commissioner of insurance for approval under s. 631.20, Stats., shall be entitled "basic health benefit plan."

(2) The term period for plan coverage shall not be less than 12 months.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

Ins 8.75 Limitations and restrictions. (1) PREEXISTING CONDITIONS. Section 635.17 (1), Stats., applies to a plan subject to this subchapter.

(2) ANNUAL MAXIMUM. The annual calendar year maximum benefit for a plan is $30,000 per insured individual. Charges for a hospitalization which extends from one calendar year to another shall be subject to the calendar year maximum for the year in which each charge was incurred and only one $100 copayment shall apply to the confinement.

(3) LIMITATION ON COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT. The annual calendar year benefit payable for treatment of a covered person for nervous and mental disorders and alcoholism and other drug abuse is $1,400. A plan may not apply the cost of outpatient prescription drugs used in the treatment of nervous and mental disorders or alcoholism or other drug abuse toward the annual limit specified in this subsection.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

Ins 8.76 Policy terms; exclusions; limitations. (1) Except as otherwise provided in this subchapter, a plan's policy terms shall be defined consistently with the definitions in the small employer insurer's other small group health benefit plans.

(2) A plan may exclude from coverage or limit coverage for specified conditions and services other than those required under s. Ins 8.72 but may exclude or limit only those conditions and services which are generally excluded from coverage or limited under the small employer insurer's other small group health benefit plans.

(3) A plan may apply the same limitations on provider choice, coverage and geographical service area that apply under the small employer insurer's other small group health benefit plans.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

Ins 8.77 Copayments; coinsurance. (1) DEFINITIONS. In this section:

(a) "Primary care provider" means any of the following:

1. If the plan is an indemnity plan, a preferred provider organization or health maintenance organization that does not require the insured to designate a primary provider, the physician who normally provides care to the insured, if the physician is any of the following:

a. A physician who is not certified by any specialty board.

b. A physician certified by the American board of family practice.

c. A physician certified by the American board of internal medicine.

d. A physician certified by the American board of obstetrics and gynecology.

e. A physician certified by the American board of pediatrics.

2. If the plan is a health maintenance organization that requires an insured to designate a primary provider, the physician designated.

(b) "Specialist" means any physician other than a primary care provider.

(2) COPAYMENTS. (a) Except as provided in par. (b), sub. (4) and s. Ins 8.79, a copayment in the specified amount applies each time an insured receives any of the following:

1. Professional services from a primary care provider or from a specialist who is consulted with a referral from a primary care provider when provided during an office visit or on an outpatient basis in a hospital, ambulatory surgery center or approved treatment facility, as defined in s. 51.01 (2), Stats.: $25.

2. Professional services from a specialist when provided during an office visit or on an outpatient basis in a hospital, ambulatory surgery center or approved treatment facility, as defined in s. 51.01 (2), Stats., when the specialist is consulted without a referral from a primary care provider: $35.

3. Professional services from a chiropractor: $11.

4. Ambulance service, unless immediately admitted to the hospital: $75.

5. Treatment in a hospital emergency room, unless immediately admitted to the hospital: $75.

6. Inpatient hospitalization: $100.

7. Prescription drugs, proprietary: $20 or the cost of the prescription, whichever is less.

8. Prescription drugs, generic: $10, or the cost of the prescription, whichever is less.

(b) The copayments specified in par. (a) 1 and 2 do not apply to professional services in connection with prenatal care or well baby care from birth to 24 months.

(3) COINSURANCE. Except as provided in sub. (4) and s. Ins 8.79, for each insured individual, a plan shall pay the following portions of the amount by which covered charges in a calendar year exceed the copayments:

(a) For all charges other than for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems:

1. 80% of the first $5,000 of charges until the plan has paid $4,000.

2. 95% of the remainder of charges until the plan limit under s. Ins 8.75 (2) has been met.

(b) For the treatment of nervous or mental disorders or alcoholism or other drug abuse problems, 80% of the charges until the plan has paid $1,400 or the plan limit under s. Ins 8.75 (2) has been met.

(4) EXCEPTION FOR HEALTH MAINTENANCE ORGANIZATIONS. A plan offered by a health maintenance organization that requires participants to use only specified health care providers may elect to offer either copay-

ments or coinsurance if the amount for which a participant is responsible is the actuarial equivalent of the copayments and coinsurance required under subs. (2) and (3). Upon request, a health maintenance organization shall provide the office of the commissioner of insurance with sufficient documentation to support its determination of actuarial equivalence.

(5) DEDUCTIBLES AND OTHER COST-SHARING PROHIBITED. A plan shall not include an annual deductible or any copayment or coinsurance requirement other than those specified in this section, except as provided in s. Ins 8.79.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

Ins 8.78 Participation; enrollment. (1) PARTICIPATION. (a) A small employer insurer shall offer a plan to any small employer meeting the definition of eligible employer in s. 635.20 (2), Stats., regardless of the number required for participation in other small group health benefit plans offered by the small employer insurer.

(b) In par. (c), the number of persons in a group means the number of eligible employes without other qualifying coverage, as defined in s. 635.02 (5m), Stats.

(c) A small employer insurer may impose participation requirements on a plan offered to a small employer, not to exceed the following:

1. For a group of more than 10 persons: 70% of the group.

2. For a group of 10 persons: 6 participants.

3. For a group of 8 or 9 persons: 5 participants.

4. For a group of 7 persons: 4 participants.

5. For a group of 5 or 6 persons: 3 participants.

6. For a group of 2 to 4 persons: 2 participants.

(2) PROBATIONARY PERIOD. A small employer may impose a waiting period of not more than 90 days from the date of hire before a new employe is eligible to enroll in the small employer's plan.

(3) ENROLLMENT. (a) A plan may require that new employes of a small employer and newly eligible dependents enroll in the plan within 30 days after becoming eligible to enroll.

(b) An eligible employe or dependent whose coverage under another health insurance plan terminates for any reason may enroll in a small employer's plan without medical underwriting within 30 days after termination of the other coverage.

(4) EMPLOYER CONTRIBUTION EXCEPTION. (a) A plan may limit coverage to eligible employes, as defined in s. 635.20 (1m), Stats., and their dependents.

(b) If a plan permits employes other than those defined as eligible employes in s. 635.20 (1m), Stats., to enroll, the small employer is not required to pay the employer contribution specified under s. 635.254 (1), Stats., for those employes. If the small employer elects not to contribute, the small employer shall withhold the entire amount of the premium

from the earnings of each employe permitted to participate, as provided in s. 635.254 (2), Stats.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

Ins 8.79 Managed care options. A small employer insurer that offers health benefit plans with one or more managed care options in the small employer market shall offer purchasers of a basic health benefit plan at least one managed care option. If the option offered is a preferred provider plan, as defined under s. 609.01 (4), Stats., the small employer insurer, in order to encourage the use of health care providers that participate in the plan, may increase any copayment specified in s. Ins 8.77 (2) or the percentage of an insured's coinsurance under s. Ins 8.77 (3) if the insured uses a nonparticipating health care provider.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

Ins 8.80 Rating. (1) In establishing the new business premium rate for the plan, a small employer insurer shall take into account the experience of all of its small employer health benefit plans. The differences between the plan's new business premium rate and the insurer's new business premium rates for all other small employer health benefit plans shall be based solely on the differences in the plan designs and not on the actual or anticipated experience of those insured under the basic health benefit plan.

(2) (a) 1. Except as provided in par. (b), the plan shall apply a higher rate to smokers than to nonsmokers. The rate applied to smokers shall be no higher than permitted under s. 111.35 (3), Stats. The small employer insurer shall provide the small employer with enough copies of the statements required under s. 111.35 (3) (a) 2 and (b) 2, Stats., for distribution to all plan participants.

2. For the purpose of complying with s. 635.05, Stats., and s. Ins 8.52, smoking status shall be treated as a case characteristic.

(b) Paragraph (a) does not apply to a health maintenance organization federally qualified under title 13 of the public health service act.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

Ins 8.81 Form approval and marketing. (1) Except as provided in s. 635.26 (2m) to (4), Stats., each small employer insurer shall file its basic health benefit plan policy form with the commissioner of insurance under s. 631.20, Stats., before October 1, 1993.

(2) Except as provided in s. 635.26 (2m) to (4), Stats., no small employer insurer shall market any health benefit plan to small employers on and after December 1, 1993 unless its basic health benefit plan policy form has been filed with and approved by the commissioner of insurance under s. 631.20, Stats.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.