State of Wisconsin
1995 - 1996 LEGISLATURE

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SENATE SUBSTITUTE AMENDMENT 1,

TO 1995 ASSEMBLY BILL 416

January 30, 1996 – Offered by COMMITTEE ON INSURANCE.

AN ACT ***to repeal*** 40.51 (8c), 60.23 (25) (a), 66.184 (2), 111.70 (4) (n), 111.91 (2) (k), 120.13 (2) (gm), 619.145 (3) (e), 619.145 (4), 619.15 (3) (bc), 619.15 (3) (bm), 619.15 (4) (e), 635.01, 635.05 and 635.26; ***to renumber*** 66.184; ***to renumber and amend*** 60.23 (25) and 635.18 (1); ***to amend*** 40.51 (8), 66.184 (1), 111.70 (1) (a), 120.13 (2) (g), 185.983 (1g), 619.135 (2), 619.135 (3), 619.14 (5) (a), 619.14 (5) (d), 619.145 (1), 619.15 (1), 619.15 (3) (c), 619.165 (1) (a), 619.165 (1) (d), 619.165 (2), 619.17 (1), 619.175, 625.12 (2), 628.34 (3) (a), 628.34 (3) (b), 632.76 (2) (a), 632.896 (4), chapter 635 (title), 635.11 (intro.), 635.11 (1), 635.11 (4), 635.13, 635.15, 635.18 (title), 635.18 (2), 635.18 (3), 635.18 (4), 635.18 (5), 635.18 (6), 635.18 (7), 635.18 (8), 635.20 (1c), 635.20 (2), 635.23 (1) (a), (d), (dp), (dr) and (e) (intro.), 1., 2. and 3., 635.23 (4) and (5), 635.25 (title), 635.25 (1) (a) (intro.), 635.25 (1) (b), 635.25 (1m), 635.25 (2), 635.254, 635.272 (1) and 635.28; ***to repeal and recreate*** 111.70 (1) (a), 111.70 (1) (a), 619.10 (3m), 619.10 (3m), 619.13, 619.13, 619.135 (2), 619.135 (2), 619.135 (3), 619.135 (3), 619.15 (3) (c), 619.15 (4) (c), 619.15 (4) (c), 619.175, 619.175, 635.02, 635.07, 635.09, 635.17, 635.20 (1m), 635.20 (13) and 635.29 (title); and ***to create*** 40.51 (8c), 40.51 (8m),

60.23 (25) (a), 60.23 (25) (h), 60.23 (25) (i), 66.184 (2), 111.70 (4) (n), 111.70 (4) (o), 111.91 (2) (k), 111.91 (2) (L), 120.13 (2) (gm), 619.145 (1m), 619.145 (3) (e), 619.145 (4), 619.15 (3) (bc), 619.15 (3) (bm), 619.15 (3) (f) and (g), 619.15 (4) (e), 632.727, 635.03, 635.04, 635.16 and 635.18 (1) (a) and (b) of the statutes; **relating to:** health insurance market reform, including preexisting condition exclusions and limitations, guaranteed issue, guaranteed acceptance, portability, rating restrictions, contract termination and renewability and fair marketing standards; funding the health insurance risk–sharing plan; collective bargaining of certain health care coverage requirements; granting rule–making authority; and making an appropriation.

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

SECTION 1. 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 632.72 (2), 632.87 (3) to (5), 632.895 (5m) and (8) to (10) ~~and,~~ 632.896, 635.03 (1) to (3) and (5) and 635.04 (3).

SECTION 2. 40.51 (8c) of the statutes is created to read:

40.51 **(8c)** Every health care coverage plan offered by the state under sub. (6) and every health care coverage plan offered by the group insurance board under sub. (7) shall comply with s. 619.13 (1) (am), (3) and (4). This subsection does not apply after June 30, 2000.

SECTION 3. 40.51 (8c) of the statutes, as created by 1995 Wisconsin Act .... (this act), is repealed.

SECTION 4. 40.51 (8m) of the statutes is created to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 635.03 (1) to (3) and (5) and 635.04.

SECTION 5. 60.23 (25) of the statutes is renumbered 60.23 (25) (intro.) and amended to read:

60.23 **(25)** SELF-INSURED HEALTH PLANS. (intro.) Provide health care benefits to its officers and employes on a self–insured basis if the self–insured plan complies with ~~ss.~~ all of the following:

(b) Section 631.89~~,~~.

(c) Section 631.90~~,~~.

(d) Section 631.93 (2)~~,~~.

(e) Section 632.87 (4) and (5)~~,~~.

(f) Section 632.895 (9) ~~and~~.

(g) Section 632.896.

SECTION 6. 60.23 (25) (a) of the statutes is created to read:

60.23 **(25)** (a) Before July 1, 2000, s. 619.13 (1) (am), (3) and (4).

SECTION 7. 60.23 (25) (a) of the statutes, as created by 1995 Wisconsin Act .... (this act), is repealed.

SECTION 8. 60.23 (25) (h) of the statutes is created to read:

60.23 **(25)** (h) Section 635.03 (2), (3) and (5) (a) 2. and (b) 2.

SECTION 9. 60.23 (25) (i) of the statutes is created to read:

60.23 **(25)** (i) Section 635.04 (3).

SECTION 10. 66.184 of the statutes is renumbered 66.184 (1).

SECTION 11. 66.184 (1) of the statutes, as affected by 1995 Wisconsin Act .... (this act), is amended to read:

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

SECTION 12. 66.184 (2) of the statutes is created to read:

66.184 **(2)** A self–insured plan under sub. (1) shall comply with s. 619.13 (1) (am), (3) and (4). This subsection does not apply after June 30, 2000.

SECTION 13. 66.184 (2) of the statutes, as created by 1995 Wisconsin Act .... (this act), is repealed.

SECTION 14. 111.70 (1) (a) of the statutes, as affected by 1995 Wisconsin Act 27, is amended to read:

111.70 **(1)** (a) "Collective bargaining" means the performance of the mutual obligation of a municipal employer, through its officers and agents, and the representative of its municipal employes in a collective bargaining unit, to meet and confer at reasonable times, in good faith, with the intention of reaching an agreement, or to resolve questions arising under such an agreement, with respect to wages, hours and conditions of employment, and with respect to a requirement of the municipal employer for a municipal employe to perform law enforcement and fire fighting services under s. 61.66, except as provided in sub. (4) (m) and (n) and s. 40.81 (3) and except that a municipal employer shall not meet and confer with respect to any proposal to diminish or abridge the rights guaranteed to municipal employes under ch. 164. The duty to bargain, however, does not compel either party to agree to a proposal or require the making of a concession. Collective bargaining includes

the reduction of any agreement reached to a written and signed document. The municipal employer shall not be required to bargain on subjects reserved to management and direction of the governmental unit except insofar as the manner of exercise of such functions affects the wages, hours and conditions of employment of the municipal employes in a collective bargaining unit. In creating this subchapter the legislature recognizes that the municipal employer must exercise its powers and responsibilities to act for the government and good order of the jurisdiction which it serves, its commercial benefit and the health, safety and welfare of the public to assure orderly operations and functions within its jurisdiction, subject to those rights secured to municipal employes by the constitutions of this state and of the United States and by this subchapter.

SECTION 15. 111.70 (1) (a) of the statutes, as affected by 1995 Wisconsin Act .... (this act), section 14, is repealed and recreated to read:

111.70 **(1)** (a) "Collective bargaining" means the performance of the mutual obligation of a municipal employer, through its officers and agents, and the representative of its municipal employes in a collective bargaining unit, to meet and confer at reasonable times, in good faith, with the intention of reaching an agreement, or to resolve questions arising under such an agreement, with respect to wages, hours and conditions of employment, and with respect to a requirement of the municipal employer for a municipal employe to perform law enforcement and fire fighting services under s. 61.66, except as provided in sub. (4) (m), (n) and (o) and s. 40.81 (3) and except that a municipal employer shall not meet and confer with respect to any proposal to diminish or abridge the rights guaranteed to municipal employes under ch. 164. The duty to bargain, however, does not compel either party to agree to a proposal or require the making of a concession. Collective bargaining includes

the reduction of any agreement reached to a written and signed document. The municipal employer shall not be required to bargain on subjects reserved to management and direction of the governmental unit except insofar as the manner of exercise of such functions affects the wages, hours and conditions of employment of the municipal employes in a collective bargaining unit. In creating this subchapter the legislature recognizes that the municipal employer must exercise its powers and responsibilities to act for the government and good order of the jurisdiction which it serves, its commercial benefit and the health, safety and welfare of the public to assure orderly operations and functions within its jurisdiction, subject to those rights secured to municipal employes by the constitutions of this state and of the United States and by this subchapter.

SECTION 16. 111.70 (1) (a) of the statutes, as affected by 1995 Wisconsin Act .... (this act), sections 14 and 15, is repealed and recreated to read:

111.70 **(1)** (a) "Collective bargaining" means the performance of the mutual obligation of a municipal employer, through its officers and agents, and the representative of its municipal employes in a collective bargaining unit, to meet and confer at reasonable times, in good faith, with the intention of reaching an agreement, or to resolve questions arising under such an agreement, with respect to wages, hours and conditions of employment, and with respect to a requirement of the municipal employer for a municipal employe to perform law enforcement and fire fighting services under s. 61.66, except as provided in sub. (4) (m) and (o) and s. 40.81 (3) and except that a municipal employer shall not meet and confer with respect to any proposal to diminish or abridge the rights guaranteed to municipal employes under ch. 164. The duty to bargain, however, does not compel either party to agree to a proposal or require the making of a concession. Collective bargaining includes

the reduction of any agreement reached to a written and signed document. The municipal employer shall not be required to bargain on subjects reserved to management and direction of the governmental unit except insofar as the manner of exercise of such functions affects the wages, hours and conditions of employment of the municipal employes in a collective bargaining unit. In creating this subchapter the legislature recognizes that the municipal employer must exercise its powers and responsibilities to act for the government and good order of the jurisdiction which it serves, its commercial benefit and the health, safety and welfare of the public to assure orderly operations and functions within its jurisdiction, subject to those rights secured to municipal employes by the constitutions of this state and of the United States and by this subchapter.

SECTION 17. 111.70 (4) (n) of the statutes is created to read:

111.70 **(4)** (n) *Health insurance risk–sharing plan surcharge.* The municipal employer is prohibited from bargaining collectively with respect to compliance with the requirements under s. 619.13 (1) (am), (3) and (4) related to payment of the surcharge for the health insurance risk–sharing plan. This paragraph does not apply after June 30, 2000.

SECTION 18. 111.70 (4) (n) of the statutes, as created by 1995 Wisconsin Act .... (this act), is repealed.

SECTION 19. 111.70 (4) (o) of the statutes is created to read:

111.70 **(4)** (o) *Health benefit plan requirements.* 1. Except as provided in subd. 2., the municipal employer is prohibited from bargaining collectively with respect to compliance with the health benefit plan requirements under subch. I of ch. 635.

2. If a municipal employer offers its employes a health care coverage plan through a program offered by the group insurance board under s. 40.51 (7), the

municipal employer is prohibited from bargaining collectively with respect to compliance with the health benefit plan requirements under ss. 635.03 (1) to (3) and (5) and 635.04 with respect to the health care coverage plan.

SECTION 20. 111.91 (2) (k) of the statutes is created to read:

111.91 **(2)** (k) Compliance with the requirements under s. 619.13 (1) (am), (3) and (4). This paragraph does not apply after June 30, 2000.

SECTION 21. 111.91 (2) (k) of the statutes, as created by 1995 Wisconsin Act .... (this act), is repealed.

SECTION 22. 111.91 (2) (L) of the statutes is created to read:

111.91 **(2)** (L) Compliance with the health benefit plan requirements under ss. 635.03 (1) to (3) and (5) and 635.04.

SECTION 23. 120.13 (2) (g) of the statutes is amended to read:

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

SECTION 24. 120.13 (2) (gm) of the statutes is created to read:

120.13 **(2)** (gm) Every self–insured plan under par. (b) shall comply with s. 619.13 (1) (am), (3) and (4). This paragraph does not apply after June 30, 2000.

SECTION 25. 120.13 (2) (gm) of the statutes, as created by 1995 Wisconsin Act .... (this act), is repealed.

SECTION 26. 185.983 (1g) of the statutes is amended to read:

185.983 **(1g)** A cooperative association that is a small employer insurer, as defined in s. ~~635.02 (8)~~ 635.20 (13), is subject to the health insurance mandates, as

defined in s. 601.423 (1), to the same extent as any other small employer insurer, as defined in s. ~~635.02 (8)~~ 635.20 (13).

SECTION 27. 619.10 (3m) of the statutes is repealed and recreated to read:

619.10 **(3m)** "Health care provider" means a person that may be a provider of a covered service or article under s. 619.14 (3), as specified by the board by rule under s. 619.15 (3) (bc). This subsection does not apply after June 30, 2000.

SECTION 28. 619.10 (3m) of the statutes, as affected by 1995 Wisconsin Act .... (this act), is repealed and recreated to read:

619.10 **(3m)** (a) "Health care coverage revenue" means any of the following:

1. Premiums received for health care coverage.

2. Subscriber contract charges received for health care coverage.

3. Health maintenance organization, limited service health organization or preferred provider plan charges received for health care coverage.

4. The sum of benefits paid and administrative costs incurred for health care coverage under a medical reimbursement plan.

(b) This subsection does not apply after 2 years after the effective date of this paragraph .... [revisor inserts date].

SECTION 29. 619.13 of the statutes is repealed and recreated to read:

619.13 Health care surcharges. (1) (a) Except as provided in sub. (2), to cover claims paid under the plan and the operating and administrative expenses of the plan, every health care provider shall impose and collect on every charge billed by the health care provider a surcharge in an amount set by the board under s. 619.15 (3) (bm) or (4) (c).

(am) Each individual or insurer or other 3rd–party payer subject to the surcharge under par. (a) shall pay the surcharge to the health care provider.

(b) A health care provider may retain up to 15% of the surcharge amounts under par. (a) that are collected before July 1, 1997, for its own administrative expenses. The board shall establish by rule the amount that a health care provider may retain of surcharges collected on and after July 1, 1997, for its administrative expenses at a level sufficient to cover the health care provider's administrative expenses. The health care provider shall remit the remainder of the surcharge amounts collected, after deducting its administrative expenses, to the board on a quarterly basis, on or before the last day of the next month following the end of each calendar quarter, along with a report that identifies any insurer or other 3rd–party payer that has failed to pay a significant surcharge amount billed during that calendar quarter.

(2) Subsection (1) does not apply to any of the following:

(a) Charges billed for services or articles provided to any of the following:

1. Medical assistance recipients.

2. Persons receiving relief under s. 49.025, 49.027 or 49.029 or under a county–funded relief program under s. 59.07 (154).

3. Persons with coverage under the plan, including an alternative plan under s. 619.145.

4. Persons with coverage under part A or part B of Title XVIII of the federal social security act, 42 USC 1395 to 1395zz.

5. Persons for whom health care benefits are provided under any other federal assistance program.

(b) Charges payable by worker's compensation insurance.

(3) An insurer or other 3rd–party payer that pays a charge for a service or article on behalf of the person receiving the service or article shall include a line item

identifying payment of the surcharge on any documentation of payment provided to the health care provider providing the service or article.

(4) The surcharge under this section shall be imposed and paid in addition to the charge for a service or article, including fees and payments for fees specified in existing contracts unless such a contract specifically provides that the fees or payments for fees specified in the contract include any surcharge that may be imposed in addition to the amount charged for a service or article.

(4m) If the person receiving the service or article, rather than an insurer or other 3rd–party payer, is paying for the service or article directly and full payment is not made in one payment, any instalment payments received by the health care provider shall be credited against the balance due on the charge for the service or article first and credited against the balance due on the surcharge only after the charge for the service or article is paid in full. This subsection does not apply if the payer specifies that a payment is intended to cover the surcharge.

(5) A health care provider is not liable for the payment of any surcharge amount imposed but not collected by the health care provider. A health care provider is immune from civil liability for imposing, collecting or attempting to collect a surcharge under this section.

(6) (a) If the surcharge under this section or its application is held by a court to be invalid with respect to any person or group of persons, then the surcharge or its application shall be invalid with respect to all persons.

(b) If the commissioner, after consulting with the attorney general, determines that the surcharge or its application is invalid under par. (a) with respect to all persons, the commissioner shall certify such determination to the revisor of statutes. Upon the certification, the revisor of statutes shall publish notice in the Wisconsin

administrative register of the determination, the date of the certification and that on the date of the certification:

1. All of the following are effective:

a. Section 619.10 (3m), 1993 stats., for 2 years.

b. Section 619.13, 1993 stats., for 2 years.

c. Section 619.135 (2) and (3), 1993 stats., for 2 years.

d. Section 619.145 (3) (e) and (4), 1993 stats., for 2 years.

e. Section 619.15 (3) (c) and (4) (c) and (e), 1993 stats., for 2 years.

f. Section 619.175, 1993 stats., for 2 years.

2. All of the following are not effective:

a. Section 619.10 (3m), 1995 stats.

b. Section 619.13, 1995 stats.

c. Section 619.135 (2) and (3), 1995 stats.

d. Section 619.15 (3) (bc), (bm) and (c) and (4) (c), 1995 stats.

e. Section 619.175, 1995 stats.

(7) This section does not apply after June 30, 2000.

SECTION 30. 619.13 of the statutes, as affected by 1995 Wisconsin Act .... (this act), is repealed and recreated to read:

619.13 Participation of insurers. (1) (a) Every insurer shall participate in the cost of administering the plan, except the commissioner may by rule exempt as a class those insurers whose share as determined under par. (b) would be so minimal as to not exceed the estimated cost of levying the assessment.

(b) Except as provided by a rule promulgated under s. 619.145 (4), every participating insurer shall share in the operating, administrative and subsidy expenses of the plan in proportion to the ratio of the insurer's total health care

coverage revenue for residents of this state during the preceding calendar year to the aggregate health care coverage revenue of all participating insurers for residents of this state during the preceding calendar year, as determined by the commissioner.

(c) If assessments and other receipts by the commissioner, board or administering carrier exceed payments made to alternative plans in accordance with contracts entered into under s. 619.145 (3) and the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board to offset future losses or to reduce plan premiums. In this paragraph, "future losses" includes reserves for incurred but not reported claims.

(d) 1. Each insurer's proportion of participation under par. (b) shall be determined annually by the commissioner based on annual statements and other reports filed by the insurer with the commissioner.

2. If the commissioner finds that the commissioner's authority to require insurers to report under chs. 600 to 646 and 655 is not adequate to permit the commissioner or the board to carry out the commissioner's or the board's responsibilities under this subchapter, the commissioner may promulgate rules requiring insurers to report the information necessary for the commissioner and the board to make the determinations required under this subchapter.

(2) Any deficit incurred under the plan shall be recouped by assessments apportioned under sub. (1) by the board among participating insurers, who may recover these amounts in the normal course of their respective businesses without time limitation.

(3) This section does not apply after 2 years after the effective date of this subsection .... [revisor inserts date].

SECTION 31. 619.135 (2) of the statutes is amended to read:

619.135 **(2)** If the moneys under s. 20.145 (7) (a) and (g) are insufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a), or the commissioner determines that the moneys under s. 20.145 (7) (a) and (g) will be insufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a), the commissioner shall, by rule, increase the amount of the assessment under sub. (1) (a) ~~or levy an assessment against every insurer, or a combination of both,~~ sufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a).

SECTION 32. 619.135 (2) of the statutes, as affected by 1995 Wisconsin Act .... (this act), section 31, is repealed and recreated to read:

619.135 **(2)** If the moneys under s. 20.145 (7) (a) and (g) are insufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a), or the commissioner determines that the moneys under s. 20.145 (7) (a) and (g) will be insufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a), the commissioner shall, by rule, increase the amount of the assessment under sub. (1) (a) or levy an assessment against every insurer, or a combination of both, sufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a).

SECTION 33. 619.135 (2) of the statutes, as affected by 1995 Wisconsin Act .... (this act), sections 31 and 32, is repealed and recreated to read:

619.135 **(2)** If the moneys under s. 20.145 (7) (a) and (g) are insufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a), or the commissioner determines that the moneys

under s. 20.145 (7) (a) and (g) will be insufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a), the commissioner shall, by rule, increase the amount of the assessment under sub. (1) (a) sufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a).

SECTION 34. 619.135 (3) of the statutes is amended to read:

619.135 **(3)** In addition to the ~~assessments~~ assessment under ~~subs.~~ sub. (1) (a) ~~and (2)~~, the commissioner may, by rule, establish an assessment to be levied against each insurer that issues a notice of rejection under s. 619.12 (1) (a) to a person who becomes eligible for and obtains coverage under the plan as a result of receiving the notice. Any assessments levied and collected under this subsection shall be credited to the appropriation under s. 20.145 (7) (g).

SECTION 35. 619.135 (3) of the statutes, as affected by 1995 Wisconsin Act .... (this act), section 34, is repealed and recreated to read:

619.135 **(3)** In addition to the assessments under subs. (1) (a) and (2), the commissioner may, by rule, establish an assessment to be levied against each insurer that issues a notice of rejection under s. 619.12 (1) (a) to a person who becomes eligible for and obtains coverage under the plan as a result of receiving the notice. Any assessments levied and collected under this subsection shall be credited to the appropriation under s. 20.145 (7) (g).

SECTION 36. 619.135 (3) of the statutes, as affected by 1995 Wisconsin Act .... (this act), sections 33 and 34, is repealed and recreated to read:

619.135 **(3)** In addition to the assessment under sub. (1) (a), the commissioner may, by rule, establish an assessment to be levied against each insurer that issues a notice of rejection under s. 619.12 (1) (a) to a person who becomes eligible for and

obtains coverage under the plan as a result of receiving the notice. Any assessments levied and collected under this subsection shall be credited to the appropriation under s. 20.145 (7) (g).

SECTION 37. 619.14 (5) (a) of the statutes is amended to read:

619.14 **(5)** (a) The plan shall offer a deductible in combination with appropriate premiums determined under this subchapter for major medical expense coverage required under this section. For coverage offered to those persons eligible for medicare, the plan shall offer a deductible equal to the deductible charged by part A of title XVIII of the federal social security act, as amended. The deductible amounts for all other eligible persons shall be dependent upon household income as determined under s. 619.165. For eligible persons under s. 619.165 (1) (b) 1., the deductible shall be $500. For eligible persons under s. 619.165 (1) (b) 2., the deductible shall be $600. For eligible persons under s. 619.165 (1) (b) 3., the deductible shall be $700. For eligible persons under s. 619.165 (1) (b) 4., the deductible shall be $800. For all other eligible persons who are not eligible for medicare, the deductible shall be $1,000. With respect to all eligible persons, expenses used to satisfy the deductible during the last 90 days of a calendar year shall also be applied to satisfy the deductible for the following calendar year. The schedule of premiums shall be promulgated by rule by the commissioner, subject to s. 619.15 (3) (f). The commissioner shall set ~~rates at 60% of the operating and administrative costs of the plan~~ premiums for eligible persons who have a household income, as defined in s. 71.52 (5) and as determined under s. 619.165 (1) (d), at or above the threshold amount established under s. 619.15 (3) (g) at a higher rate than premiums for eligible persons who have a household income below the threshold amount.

SECTION 38. 619.14 (5) (d) of the statutes is amended to read:

619.14 **(5)** (d) Notwithstanding pars. (a) to (c), the board may establish different deductible amounts, a different coinsurance percentage and different covered costs and deductible aggregate amounts from those specified in pars. (a) to (c) in accordance with cost containment provisions established by the commissioner under s. 619.17 (4) (a) and for individuals who enroll in an alternative plan under s. 619.145 or who are unable to enroll in an alternative plan because of the unavailability of such a plan in the individual's geographic area.

SECTION 39. 619.145 (1) of the statutes is amended to read:

619.145 **(1)** ~~The~~ Except as provided in sub. (1m), the board may offer to persons eligible for coverage under s. 619.12 the opportunity to enroll, on a voluntary basis, in an alternative plan that uses managed care and that the commissioner determines provides benefits that are substantially equivalent to or greater than the benefits provided under the plan. A person who voluntarily enrolls in an alternative plan under this section is ineligible for coverage under the plan for 12 months after enrolling in the alternative plan.

SECTION 40. 619.145 (1m) of the statutes is created to read:

619.145 **(1m)** (a) The board shall promulgate rules that implement the use of alternative plans that use managed care and capitation or other risk–sharing mechanisms and that the commissioner determines provide benefits for persons who use the services of providers designated by the alternative plan that are substantially equivalent to or greater than the benefits provided under the plan.

(b) Beginning on July 1, 1997, the board shall offer to persons eligible for coverage under s. 619.12 the opportunity to enroll, and may require such persons to enroll, in an alternative plan.

(c) Notwithstanding s. 619.14 (5) (a), the board may by rule establish premiums for persons who enroll in an alternative plan that are different from premiums for persons who do not enroll in an alternative plan to reflect the differences in the cost of covered services and articles. A person who is unable to enroll in an alternative plan because of the unavailability of such a plan in the person's geographic area, however, shall be allowed to pay the same premium rate as persons who do enroll in an alternative plan.

SECTION 41. 619.145 (3) (e) of the statutes is repealed.

SECTION 42. 619.145 (3) (e) of the statutes is created to read:

619.145 **(3)** (e) Subject to sub. (4), a reduction in the alternative plan's assessment under s. 619.13 for operating and administrative, but not subsidy, expenses of the plan. This paragraph does not apply after 2 years after the effective date of this paragraph .... [revisor inserts date].

SECTION 43. 619.145 (4) of the statutes is repealed.

SECTION 44. 619.145 (4) of the statutes is created to read:

619.145 **(4)** A contract under sub. (3) may not provide for a reduction in the assessment under s. 619.13 against an alternative plan unless the assessment reduction has been adopted by rule under s. 619.15 (4) (e). This subsection does not apply after 2 years after the effective date of this subsection .... [revisor inserts date].

SECTION 45. 619.15 (1) of the statutes is amended to read:

619.15 **(1)** The plan shall operate subject to the supervision and approval of a board consisting of representatives of ~~2 participating insurers which are nonprofit corporations, 2 other participating insurers~~ 3 insurers and 3 health care providers, and 3 public members, appointed by the commissioner for ~~staggered~~ 3–year terms. In addition, the commissioner or a designated representative from the office of the

commissioner shall be a member of the board. The public members shall not be professionally affiliated with the practice of medicine, a hospital or an insurer. At least 2 of the public members shall be individuals reasonably expected to qualify for coverage under the plan or the parent or spouse of such an individual. The commissioner or the commissioner's representative shall be the chairperson of the board. Board members, except the commissioner or the commissioner's representative, shall be compensated at the rate of $50 per diem plus actual and necessary expenses.

SECTION 46. 619.15 (3) (bc) of the statutes is created to read:

619.15 **(3)** (bc) Specify all persons that are required to impose and collect the surcharge under s. 619.13 (1) (a). The board shall include every type of provider that may provide a covered service or article under s. 619.14 (3). This paragraph does not apply after June 30, 2000.

SECTION 47. 619.15 (3) (bc) of the statutes, as created by 1995 Wisconsin Act .... (this act), is repealed.

SECTION 48. 619.15 (3) (bm) of the statutes is created to read:

619.15 **(3)** (bm) Set the amount of the surcharge under s. 619.13 (1) (a) at a level that is sufficient to cover claims paid under the plan, the operating and administrative expenses of the plan and the administrative expenses that may be retained by health care providers under s. 619.13 (1) (b) at a level sufficient to cover a health care provider's administrative expenses. The amount shall be a flat encounter fee, and the board may provide for different surcharge amounts for different services or articles. This paragraph does not apply after June 30, 2000.

SECTION 49. 619.15 (3) (bm) of the statutes, as created by 1995 Wisconsin Act .... (this act), is repealed.

SECTION 50. 619.15 (3) (c) of the statutes is amended to read:

619.15 **(3)** (c) Collect ~~assessments~~ surcharges from all ~~insurers~~ health care providers to provide for claims paid under the plan and for administrative expenses ~~incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board. Assessment of the insurers shall occur at the end of each calendar year or other fiscal year end established by the board. Assessments are due and payable within 30 days of receipt by the insurer of the assessment notice~~. The board shall ensure that all surcharges are deposited in the health insurance risk–sharing plan fund. This paragraph does not apply after June 30, 2000.

SECTION 51. 619.15 (3) (c) of the statutes, as affected by 1995 Wisconsin Act .... (this act), is repealed and recreated to read:

619.15 **(3)** (c) Collect assessments from all insurers to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board. Assessment of the insurers shall occur at the end of each calendar year or other fiscal year end established by the board. Assessments are due and payable within 30 days of receipt by the insurer of the assessment notice. This paragraph does not apply after 2 years after the effective date of this paragraph .... [revisor inserts date].

SECTION 52. 619.15 (3) (f) and (g) of the statutes are created to read:

619.15 **(3)** (f) Determine the percentage, but not less than 60%, of the operating and administrative costs of the plan at which the commissioner must set premium rates under s. 619.14 (5) (a).

(g) Establish a threshold amount for the household income, as defined in s. 71.52 (5) and as determined under s. 619.165 (1) (d), of an eligible person for purposes of determining premium rates under s. 619.14 (5) (a).

SECTION 53. 619.15 (4) (c) of the statutes is repealed and recreated to read:

619.15 **(4)** (c) Adjust the surcharge amount under sub. (3) (bm) to ensure adequate funding for the payment of claims, the operating and administrative expenses of the plan and the administrative expenses retained by health care providers. This paragraph does not apply after June 30, 2000.

SECTION 54. 619.15 (4) (c) of the statutes, as affected by 1995 Wisconsin Act .... (this act), is repealed and recreated to read:

619.15 **(4)** (c) In addition to assessments imposed under sub. (3) (c), levy interim assessments to ensure the financial ability of the plan to cover claims expense and administrative expenses incurred or estimated to be incurred in the operation of the plan prior to the end of the calendar year end or other fiscal year end established by the board. Interim assessments shall be due and payable within 30 days of receipt by an insurer of an interim assessment notice. Interim assessments shall be credited against each insurer's annual assessment. This paragraph does not apply after 2 years after the effective date of this paragraph .... [revisor inserts date].

SECTION 55. 619.15 (4) (e) of the statutes is repealed.

SECTION 56. 619.15 (4) (e) of the statutes is created to read:

619.15 **(4)** (e) By rule provide for a reduction in the assessment under s. 619.13 against an alternative plan that provides coverage to eligible persons. This paragraph does not apply after 2 years after the effective date of this paragraph .... [revisor inserts date].

SECTION 57. 619.165 (1) (a) of the statutes is amended to read:

619.165 **(1)** (a) The board shall reduce the premiums established by the commissioner under s. 619.11 in conformity with ss. 619.14 (5), 619.15 (3) (f) and (g) and 619.17 or established by the board under s. 619.145 (1m) (c), for the eligible persons and in the manner set forth in pars. (b) to (d).

SECTION 58. 619.165 (1) (d) of the statutes is amended to read:

619.165 **(1)** (d) The board shall establish and implement the method for determining the household income of an eligible person under par. (b) and under ss. 619.14 (5) (a) and 619.15 (3) (g).

SECTION 59. 619.165 (2) of the statutes is amended to read:

619.165 **(2)** The board shall direct the administering carrier to collect, under s. 619.16 (3) (b), from the eligible persons under sub. (1) the premiums as reduced under sub. (1) rather than the premiums established by the commissioner or by the board.

SECTION 60. 619.17 (1) of the statutes is amended to read:

619.17 **(1)** Subject to ~~s.~~ ss. 619.14 (5) (a) and 619.15 (3) (f) and (g), a rating plan calculated in accordance with generally accepted actuarial principles.

SECTION 61. 619.175 of the statutes is amended to read:

619.175 Waiver or exemption from provisions prohibited. ~~Except as provided in s. 619.13 (1) (a), the~~ The commissioner may not waive, or authorize the board to waive, any of the requirements of this subchapter or exempt, or authorize the board to exempt, an individual or a class of individuals from any of the requirements of this subchapter.

SECTION 62. 619.175 of the statutes, as affected by 1995 Wisconsin Act .... (this act), section 61, is repealed and recreated to read:

619.175 Waiver or exemption from provisions prohibited. Except as provided in s. 619.13 (1) (a), the commissioner may not waive, or authorize the board to waive, any of the requirements of this subchapter or exempt, or authorize the board to exempt, an individual or a class of individuals from any of the requirements of this subchapter.

SECTION 63. 619.175 of the statutes, as affected by 1995 Wisconsin Act .... (this act), sections 55 and 56, is repealed and recreated to read:

619.175 Waiver or exemption from provisions prohibited. The commissioner may not waive, or authorize the board to waive, any of the requirements of this subchapter or exempt, or authorize the board to exempt, an individual or a class of individuals from any of the requirements of this subchapter.

SECTION 64. 625.12 (2) of the statutes is amended to read:

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

SECTION 65. 628.34 (3) (a) of the statutes is amended to read:

628.34 **(3)** (a) No insurer may unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage except on the basis of classifications related to the nature and the degree of the risk covered or the

expenses involved, subject to ~~s.~~ ss. 632.365, 635.03, 635.09 and 635.16. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket or franchise policy, and terms are not unfairly discriminatory merely because they are more favorable than in a similar individual policy.

SECTION 66. 628.34 (3) (b) of the statutes is amended to read:

628.34 **(3)** (b) No insurer may refuse to insure or refuse to continue to insure, or limit the amount, extent or kind of coverage available to an individual, or charge an individual a different rate for the same coverage because of a mental or physical disability except when the refusal, limitation or rate differential is based on either sound actuarial principles supported by reliable data or actual or reasonably anticipated experience, subject to ss. 635.03 to 635.09, 635.16 and 635.17.

SECTION 67. 632.727 of the statutes is created to read:

632.727 Electronic claims capability. (1) DEFINITION. In this section, "health care provider" has the meaning given in s. 146.81 (1) (a) to (m) and (p).

(2) INSURERS. Beginning on January 1, 1997, every insurer that offers disability insurance must have and use the capability to accept all claims electronically.

(3) HEALTH CARE PROVIDERS. (a) Beginning on January 1, 1997, every health care provider that has annual gross revenues of more than $1,000,000 must have and use the capability to electronically transmit disability insurance claims information.

(b) Beginning on January 1, 1998, every health care provider not specified in par. (a) must have and use the capability to electronically transmit disability insurance claims information.

SECTION 68. 632.76 (2) (a) of the statutes is amended to read:

632.76 **(2)** (a) No claim for loss incurred or disability commencing after 2 years from the date of issue of the policy may be reduced or denied on the ground that a

disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of loss. This paragraph does not apply to a health benefit plan, as defined in s. 635.02 (3), which is subject to s. 635.03 (2) or 635.16 (2).

SECTION 69. 632.896 (4) of the statutes is amended to read:

632.896 **(4)** PREEXISTING CONDITIONS. Notwithstanding ~~s.~~ ss. 632.76 (2) (a), 635.03 (2) and 635.16 (2), a disability insurance policy that is subject to sub. (2) and that is in effect when a court makes a final order granting adoption or when the child is placed for adoption may not exclude or limit coverage of a disease or physical condition of the child on the ground that the disease or physical condition existed before coverage is required to begin under sub. (3).

SECTION 70. Chapter 635 (title) of the statutes is amended to read:

CHAPTER 635

~~SMALL EMPLOYER~~ REGULATION

OF HEALTH INSURANCE

SECTION 71. 635.01 of the statutes is repealed.

SECTION 72. 635.02 of the statutes is repealed and recreated to read:

635.02 Definitions. In this subchapter:

(1) "Basic health benefit plan" means a small employer health insurance plan under subch. II.

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

(3) "Health benefit plan" means any hospital or medical policy or certificate. "Health benefit plan" does not include accident–only, credit accident or health, dental, vision, medicare supplement, medicare replacement, long–term care, disability income or short–term insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance, student–only medical plans, policies issued to medicaid recipients, individual conversion policies, specified disease policies, hospital indemnity policies, as defined in s. 632.895 (1) (c), policies or certificates issued under the health insurance risk–sharing plan or an alternative plan under subch. II of ch. 619 or other insurance exempted by rule of the commissioner.

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

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

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

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

SECTION 73. 635.03 of the statutes is created to read:

635.03 Coverage requirements for all group health benefit plans. (1) DEFINITIONS. In this section and s. 635.04:

(a) 1. Except as provided in subd. 2., "eligible employe" means an employe who works on a permanent basis and has a normal workweek of 30 or more hours. The term includes a sole proprietor, a business owner, including the owner of a farm business, a partner of a partnership and a member of a limited liability company if the sole proprietor, business owner, partner or member is included as an employe under a health benefit plan of an employer, but the term does not include an employe who works on a temporary or substitute basis.

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

(b) "Employer" means any of the following:

1. An individual, firm, corporation, partnership, limited liability company or association that is actively engaged in a business enterprise in this state, including a farm business.

2. A municipality, as defined in s. 16.70 (8).

3. The state.

(c) "Group health benefit plan" means a health benefit plan that is issued by an insurer to an employer on behalf of a group consisting of eligible employes of the employer. The term includes individual health benefit plans covering eligible employes when 3 or more are sold to an employer.

(d) "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers group health benefit plans covering eligible employes of one or more employers in

this state. The term includes a health maintenance organization, as defined in s. 609.01 (2), a preferred provider plan, as defined in s. 609.01 (4), an insurer operating as a cooperative association organized under ss. 185.981 to 185.985 and a limited service health organization, as defined in s. 609.01 (3).

(e) 1. "Qualifying coverage" means benefits or coverage provided under any of the following:

a. Medicare or medicaid.

b. A group health benefit plan or an employer–based health benefit arrangement that provides benefits similar to or exceeding benefits provided under a basic health benefit plan.

c. An individual health benefit plan that provides benefits similar to or exceeding benefits provided under a basic health benefit plan, if the individual health benefit plan has been in effect for at least one year.

2. Notwithstanding subd. 1. b. and c., "qualifying coverage" does not include catastrophic coverage that is linked to a tax–preferred savings plan for payment of medical expenses.

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

(2) PREEXISTING CONDITIONS. (a) A group health benefit plan, or a self–insured health plan, may not deny, exclude or limit benefits for a covered individual for losses incurred more than 12 months after the effective date of the individual's coverage due to a preexisting condition.

(b) Except as provided in par. (c), a group health benefit plan, or a self–insured health plan, may not define a preexisting condition more restrictively than any of the following:

1. A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the 6 months immediately preceding the effective date of coverage and for which the individual did not seek medical advice, diagnosis, care or treatment.

2. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the effective date of coverage.

(c) Notwithstanding par. (b) 1. and 2., a group health benefit plan, or a self–insured health plan, shall exclude pregnancy from the definition of a preexisting condition for the purpose of coverage of expenses related to prenatal and postnatal care, delivery and any complications of pregnancy.

(3) PORTABILITY. (a) A group health benefit plan, or a self–insured health plan, shall waive any period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period that an individual was previously covered by qualifying coverage that was not sponsored by the employer sponsoring the group health benefit plan or the self–insured health plan and that provided benefits with respect to such services, if the qualifying coverage terminated not more than 60 days before the effective date of the new coverage.

(b) Paragraph (a) does not prohibit the application of a waiting period to all new enrollees under a group health benefit plan or a self–insured health plan; however, a waiting period may not be applied when determining whether the qualifying coverage terminated not more than 60 days before the effective date of the new coverage.

(4) MINIMUM PARTICIPATION OF EMPLOYES. (a) Except as provided in par. (d), requirements used by an insurer in determining whether to provide coverage under

a group health benefit plan to an employer, including requirements for minimum participation of eligible employes and minimum employer contributions, shall be applied uniformly among all employers that apply for or receive coverage from the insurer.

(b) An insurer may vary its minimum participation requirements and minimum employer contribution requirements only by the size of the employer group based on the number of eligible employes.

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

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

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

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

2. Except as provided in rules promulgated under subd. 3., if the state or a county, city, village, town or school district offers coverage under a self–insured health plan, it shall offer coverage to all of its eligible employes and their dependents. Except as provided in rules promulgated under subd. 3., the state or a county, city, village, town or school district may not offer coverage to only certain individuals in the employer group or to only part of the group, except for an eligible employe who has not yet satisfied an applicable waiting period, if any.

3. The secretary of employe trust funds, with the approval of the group insurance board, shall promulgate rules related to offering coverage to eligible employes under a group health benefit plan, or a self–insured health plan, offered by the state under s. 40.51 (6) or by the group insurance board under s. 40.51 (7). The rules shall conform to the intent of subds. 1. and 2. and may not allow the state or the group insurance board to refuse to offer coverage to an eligible employe or dependent for reasons related to health condition.

(b) 1. An insurer may not modify a group health benefit plan with respect to an employer or an eligible employe or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the group health benefit plan.

2. The state or a county, city, village, town or school district may not modify a self–insured health plan with respect to an eligible employe or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the self–insured health plan.

3. Nothing in this paragraph limits the authority of the group insurance board to fulfill its obligations as trustee under s. 40.03 (6) (d) or to design or modify

procedures or provisions pertaining to enrollment, premium transmitted or coverage of eligible employes for health care benefits under s. 40.51 (1).

SECTION 74. 635.04 of the statutes is created to read:

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

(a) The employe has satisfied any applicable waiting period.

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

(2) EMPLOYE WAIVED COVERAGE PREVIOUSLY. If an insurer provides coverage under a group health benefit plan, the insurer shall provide coverage under the group health benefit plan to an eligible employe who waived coverage during an enrollment period during which the employe was entitled to enroll in the group health benefit plan, regardless of health condition or claims experience, if all of the following apply:

(a) The eligible employe was covered as a dependent under qualifying coverage when he or she waived coverage under the group health benefit plan.

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

(c) The eligible employe applies for coverage under the group health benefit plan not more than 30 days after termination of his or her coverage under the qualifying coverage.

(d) The employer agrees to pay the premium required for coverage of the employe under the group health benefit plan.

(3) STATE OR MUNICIPAL SELF–INSURED PLANS. If the state or a county, city, village, town or school district provides coverage under a self–insured health plan, it shall provide coverage under the self–insured health plan to an eligible employe who waived coverage during an enrollment period during which the employe was entitled to enroll in the self–insured health plan, regardless of health condition or claims experience, if all of the following apply:

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

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

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

SECTION 75. 635.05 of the statutes is repealed.

SECTION 76. 635.07 of the statutes is repealed and recreated to read:

635.07 Guaranteed issue for certain group health benefit plans. (1) DEFINITIONS. In this section and ss. 635.09 to 635.15:

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

(b) "Benefit design characteristics" means covered services, cost sharing, utilization management, managed care networks and other features that differentiate plan or coverage designs.

(c) "Case characteristics" means the age, gender, geographic location and tobacco use of the individuals covered under a health benefit plan.

(d) "Eligible employe" means an employe who works on a permanent basis and has a normal workweek of 30 or more hours. The term includes a sole proprietor, a business owner, including the owner of a farm business, a partner of a partnership and a member of a limited liability company if the sole proprietor, business owner, partner or member is included as an employe under a health benefit plan of an employer, but the term does not include an employe who works on a temporary or substitute basis.

(e) "Employer" means any of the following:

1. An individual, firm, corporation, partnership, limited liability company or association that is actively engaged in a business enterprise in this state, including a farm business, and that employs in this state not fewer than 2 nor more than 100 eligible employes. In determining the number of eligible employes, employers that are affiliated, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

2. A municipality, as defined in s. 16.70 (8), that employs not fewer than 2 nor more than 100 eligible employes.

(f) "Group health benefit plan" means a health benefit plan that is issued by an insurer to an employer on behalf of a group consisting of eligible employes of the employer. The term includes individual health benefit plans covering eligible employes when 3 or more are sold to an employer.

(g) "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers group health benefit plans covering eligible employes of one or more employers in this state, or that sells individual health benefit plans to individuals who are residents of this state. The term includes a health maintenance organization, as defined in s. 609.01 (2), a preferred provider plan, as defined in s. 609.01 (4), an insurer operating as a cooperative association organized under ss. 185.981 to 185.985 and a limited service health organization, as defined in s. 609.01 (3).

(h) "Midpoint rate" means the arithmetic average of the base premium rate and the corresponding highest premium rate.

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

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

(2) REQUIREMENT. Except as provided in subs. (3) and (4), an insurer shall provide coverage under a group health benefit plan to an employer and to all of the employer's eligible employes and their dependents, regardless of health condition or claims experience, if all of the following apply:

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

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

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

(2m) PAYMENT SECURITY PROVISIONS ALLOWED. An insurer that provides coverage under sub. (2) may impose payment security provisions that are reasonably related to the risk covered.

(3) EXCEPTIONS TO GUARANTEED ISSUE. (a) An insurer that is otherwise required to provide coverage under sub. (2) may refuse to issue a group health benefit plan to an employer if all of the individuals in the employer group that are to be covered under the group health benefit plan may be covered under one individual health benefit plan providing family coverage.

(b) Subsection (2) does not require an insurer to issue coverage that the insurer is not authorized to issue under its bylaws, charter or certificate of incorporation or authority.

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

(d) An insurer that offers health care coverage exclusively to a single category or limited categories of employers may, with prior approval of the commissioner, limit its compliance with sub. (2) to that single category or those limited categories of employers.

(e) The commissioner may exempt an insurer from the requirements of sub. (2) if the commissioner determines that it is in the public interest to exempt the insurer from the requirements under sub. (2) because the insurer is in financially hazardous condition.

(f) If an employer loses coverage under a group health benefit plan for failure to pay a premium when due, an insurer that is otherwise required to provide coverage under sub. (2) may refuse to issue a group health benefit plan to that employer during the 12–month period after the date on which the employer lost coverage.

(g) 1. In this paragraph, "small employer" means an employer that employs in this state not fewer than 2 nor more than 25 eligible employes. In determining the number of eligible employes, employers that are affiliated, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

2. An insurer that previously issued group health benefit plans but, prior to the effective date of this subdivision .... [revisor inserts date], discontinued offering such plans to small employers, shall within 60 days after the effective date of this subdivision .... [revisor inserts date], again offer group health benefit plans to small employers or be subject to the requirements under s. 635.17 (2) (a) as if the insurer had elected to not renew a group health benefit plan.

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

(b) An insurer that is otherwise required to provide coverage under sub. (2) shall be exempt from the requirement under sub. (2) for the remainder of a calendar year after all of the following occur:

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

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

(c) Whenever an insurer becomes exempt from the requirement under sub. (2) by satisfying the criteria under par. (b), the commissioner shall provide notice of that exemption to all insurers to which this section applies and to all insurance agents listed under s. 628.11 by the insurers to which this section applies.

(d) An insurer that satisfies the criterion under par. (b) 1. is not required to apply for exemption from the requirement under sub. (2). An insurer that does not apply for exemption shall remain subject to the requirement under sub. (2).

(e) In consultation with the committee on risk adjustment, the commissioner shall promulgate rules for the operation of the risk adjustment mechanism under this subsection, including rules that specify at least all of the following:

1. What diagnostic conditions constitute high risk medical conditions for purposes of the definition of a high–risk individual.

2. How to determine an insurer's highest premium rate level for purposes of the definition of a high–risk individual.

3. What percentage of an insurer's total enrollment under group health benefit plans issued by the insurer constitutes the threshold level for purposes of par. (b) 1.

SECTION 77. 635.09 of the statutes is repealed and recreated to read:

635.09 Rate regulation for individual and certain group health benefit plans. Notwithstanding ch. 625, the commissioner shall promulgate rules that do all of the following:

(1) Establish restrictions on premium rates that an insurer may charge an employer for coverage under a group health benefit plan such that the premium rates charged to employers with similar case characteristics for the same or similar benefit design characteristics do not vary from the midpoint rate for those employers by more than 30% of that midpoint rate.

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

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

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

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

2. An adjustment, not to exceed 15% per year for employers with 2 to 50 eligible employes or 25% per year for employers with 51 to 100 eligible employes, adjusted proportionally for rating periods of less than one year, for such rating factors as claims experience, health condition and duration of coverage, determined in accordance with the insurer's rate manual or rating procedures.

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

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

(3) Require the premium rate of a health benefit plan issued before the effective date of this subsection .... [revisor inserts date], to comply with the rules promulgated under sub. (1) or (1m) no later than 2 years after the effective date of this subsection .... [revisor inserts date].

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

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

(6) Ensure that rating factors are applied objectively and consistently to employers with 2 to 50 eligible employes.

SECTION 78. 635.11 (intro.) of the statutes is amended to read:

635.11 (title) **Disclosure of rating factors and renewability provisions for certain group health benefit plans.** (intro.) Before the sale of a group health benefit plan ~~or policy subject to this subchapter, a small employer,~~ an insurer shall disclose to ~~a small~~ an employer all of the following:

SECTION 79. 635.11 (1) of the statutes is amended to read:

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

SECTION 80. 635.11 (4) of the statutes is amended to read:

635.11 **(4)** The ~~small~~ employer's renewability rights.

SECTION 81. 635.13 of the statutes is amended to read:

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

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

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

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

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

SECTION 82. 635.15 of the statutes is amended to read:

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

SECTION 83. 635.16 of the statutes is created to read:

635.16 Coverage requirements for individual health benefit plans. (1) DEFINITIONS. In this section:

(a) "Employer" has the meaning given in s. 635.03 (1) (b).

(b) "Group health benefit plan" has the meaning given in s. 635.03 (1) (c).

(c) "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that sells individual health benefit plans to individuals who are residents of this state. The term includes a health maintenance organization, as defined in s. 609.01 (2), a preferred provider plan, as defined in s. 609.01 (4), an insurer operating as a cooperative association organized under ss. 185.981 to 185.985 and a limited service health organization, as defined in s. 609.01 (3).

(d) 1. "Qualifying coverage" means benefits or coverage provided under any of the following:

a. A group health benefit plan or an employer–based health benefit arrangement that provides benefits similar to or exceeding benefits provided under the health benefit plan for which the individual is applying.

b. An individual health benefit plan that provides benefits similar to or exceeding benefits provided under the health benefit plan for which the individual is applying, if the individual health benefit plan has been in effect for at least one year.

2. Notwithstanding subd. 1. a. and b., "qualifying coverage" does not include catastrophic coverage that is linked to a tax–preferred savings plan for payment of medical expenses.

(2) PREEXISTING CONDITIONS. (a) An individual health benefit plan may not deny, exclude or limit benefits for a covered individual for losses incurred more than 12 months after the effective date of the individual's coverage due to a preexisting condition.

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

1. A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the 18 months immediately preceding the effective date of coverage and for which the individual did not seek medical advice, diagnosis, care or treatment.

2. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the 18 months immediately preceding the effective date of coverage.

3. A pregnancy existing on the effective date of coverage.

(3) LIMITED GUARANTEED ISSUE, PORTABILITY AND OTHER COVERAGE REQUIREMENTS. (a) Except as provided in pars. (b) and (g), an insurer shall provide coverage under an individual health benefit plan to an individual who is a resident of this state, regardless of health condition or claims experience, if all of the following apply:

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

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

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

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

5. If the individual's qualifying coverage under subd. 4. was coverage under sub. (1) (d) 1. a., the individual had been covered under continuation coverage, as defined in s. 252.16 (1) (a), for the maximum allowable period; the individual is not now eligible for coverage under any group health benefit plan or employer–based health benefit arrangement; and the individual was an eligible employe, as defined in s. 635.03 (1) (a), for at least 6 months immediately before applying for the new coverage.

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

2. Paragraph (a) does not require an insurer that provides coverage to an individual under an individual health benefit plan to issue a different individual

health benefit plan to the individual before the expiration of the agreed term of the individual health benefit plan under which the individual has coverage.

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

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

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

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

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

(f) An individual health benefit plan that is issued to an individual described in par. (a) shall waive any period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period that the individual

was covered with respect to such services under the individual's qualifying coverage under par. (a) 4.

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

1. The total number of individuals described under par. (a) and their dependents who are covered by the insurer equals at least 1% of the total number of individuals and their dependents covered under all individual health benefit plans issued by the insurer that were in effect on December 31 of the preceding year and that were qualifying coverage under sub. (1) (d) 1. b.

2. The insurer applies for exemption from the requirement under par. (a) by submitting to the commissioner certification that includes all of the following:

a. The total number of individuals and their dependents covered under all individual health benefit plans issued by the insurer that were in effect on December 31 of the preceding year and that were qualifying coverage under sub. (1) (d) 1. b.

b. The total number of individuals described under par. (a) and their dependents who have been accepted by the insurer for coverage under par. (a) during the current year.

(h) Whenever an insurer becomes exempt from the requirement under par. (a) by satisfying the criteria under par. (g), the commissioner shall provide notice of that exemption to all insurers to which this subsection applies and to all insurance agents listed under s. 628.11 by the insurers to which this subsection applies.

SECTION 84. 635.17 of the statutes is repealed and recreated to read:

635.17 Contract termination and renewability for all group and individual health benefit plans. (1) DEFINITIONS. In this section and s. 635.18:

(a) "Eligible employe" has the meaning given in s. 635.03 (1) (a).

(b) "Employer" has the meaning given in s. 635.03 (1) (b).

(c) "Established geographic service area" means a geographic area within which an insurer provides coverage and that has been approved by the commissioner.

(d) "Group health benefit plan" has the meaning given in s. 635.03 (1) (c).

(e) "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers group health benefit plans covering eligible employes of one or more employers in this state, or that sells individual health benefit plans to individuals who are residents of this state. The term includes a health maintenance organization, as defined in s. 609.01 (2), a preferred provider plan, as defined in s. 609.01 (4), and an insurer operating as a cooperative association organized under ss. 185.981 to 185.985 and a limited service health organization, as defined in s. 609.01 (3).

(f) "Restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on obtaining services or articles from health care providers that have contracted with the insurer to provide health care services or articles to covered individuals.

(1m) MIDTERM CANCELLATION. Notwithstanding s. 631.36 (2) to (4m), a health benefit plan may not be canceled by an insurer before the expiration of the agreed term, and shall be renewable to the policyholder and all insureds and dependents eligible under the terms of the health benefit plan at the expiration of the agreed term at the option of the policyholder, except for any of the following reasons:

(a) Failure to pay a premium when due.

(b) Fraud or misrepresentation by the policyholder, or, with respect to coverage for an insured individual, fraud or misrepresentation by that insured individual.

(c) Substantial breaches of contractual duties, conditions or warranties.

(d) If a group health benefit plan, the number of individuals covered under the group health benefit plan is less than the number required by the group health benefit plan.

(e) If a group health benefit plan, the employer to which the group health benefit plan is issued is no longer actively engaged in a business enterprise.

(2) NONRENEWAL. (a) Notwithstanding sub. (1m), an insurer that issues group health benefit plans may elect not to renew a group health benefit plan if the insurer complies with all of the following:

1. The insurer ceases to renew all other group health benefit plans issued by the insurer.

2. The insurer provides notice to all affected policyholders and to the commissioner in each state in which an affected insured individual resides at least one year before termination of coverage.

3. The insurer does not issue a group health benefit plan before 5 years after the nonrenewal of the group health benefit plans.

4. The insurer does not transfer or otherwise provide coverage to a policyholder from the nonrenewed business unless the insurer offers to transfer or provide coverage to all affected policyholders from the nonrenewed business without regard to claims experience, health condition or duration of coverage.

(b) Notwithstanding sub. (1m), an insurer that issues individual health benefit plans may elect not to renew an individual health benefit plan if the insurer complies with all of the following:

1. The insurer ceases to renew all other individual health benefit plans issued by the insurer.

2. The insurer provides notice to all affected policyholders and to the commissioner in each state in which an affected insured individual resides at least one year before termination of coverage.

3. The insurer does not issue an individual health benefit plan before 5 years after the nonrenewal of the individual health benefit plans.

4. The insurer does not transfer or otherwise provide coverage to a policyholder from the nonrenewed business unless the insurer offers to transfer or provide coverage to all affected policyholders from the nonrenewed business without regard to claims experience, health condition or duration of coverage.

(3) INSURER IN LIQUIDATION. This section does not apply to a health benefit plan if the insurer that issued the health benefit plan is in liquidation.

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

SECTION 85. 635.18 (title) of the statutes is amended to read:

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

SECTION 86. 635.18 (1) of the statutes is renumbered 635.18 (1) (intro.) and amended to read:

635.18 **(1)** (intro.) Every ~~small employer~~ insurer that provides coverage under a health benefit plan shall actively market such health benefit plan coverage~~, including basic health benefit plans, to small employers in the state. If a small employer insurer denies coverage to a small employer under a health benefit plan that is not a basic health benefit plan on the basis of the health status or claims experience of the small employer or its eligible employes or their dependents, the~~

~~small employer insurer shall offer the small employer the opportunity to purchase a basic health benefit plan~~. In addition to other marketing limitations that the commissioner may authorize by rule, an insurer may limit its marketing under this subsection to any of the following:

SECTION 87. 635.18 (1) (a) and (b) of the statutes are created to read:

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

(b) Health benefit plans for individuals.

SECTION 88. 635.18 (2) of the statutes is amended to read:

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

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

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

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

SECTION 89. 635.18 (3) of the statutes is amended to read:

635.18 **(3)** (a) Except as provided in par. (b), ~~a small employer~~ an insurer may not, directly or indirectly, enter into any contract, agreement or arrangement with an intermediary that provides for or results in compensation to ~~an~~ the intermediary

for the sale of a health benefit plan that varies according to the health ~~status~~ condition, claims experience, industry, occupation or geographic ~~location~~ area of the ~~small~~ employer ~~or,~~ eligible employes, insured individual or dependents.

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

(c) ~~A small employer~~ An insurer shall provide reasonable compensation to an intermediary, if any, for the sale of a basic health benefit plan.

SECTION 90. 635.18 (4) of the statutes is amended to read:

635.18 **(4)** ~~A small employer~~ An insurer may not terminate, fail to renew or limit its contract or agreement of representation with an intermediary for any reason related to the health ~~status~~ condition, claims experience, occupation or geographic ~~location~~ area of the ~~small~~ employers ~~or,~~ eligible employes, insured individuals or ~~their~~ dependents placed by the intermediary with the ~~small employer~~ insurer.

SECTION 91. 635.18 (5) of the statutes is amended to read:

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

SECTION 92. 635.18 (6) of the statutes is amended to read:

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

SECTION 93. 635.18 (7) of the statutes is amended to read:

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

SECTION 94. 635.18 (8) of the statutes is amended to read:

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

SECTION 95. 635.20 (1c) of the statutes is amended to read:

635.20 **(1c)** "Dependent" has the meaning given in s. 635.02 ~~(3c)~~ (2).

SECTION 96. 635.20 (1m) of the statutes is repealed and recreated to read:

635.20 **(1m)** "Eligible employe" means an employe of a small employer who works on a permanent basis and has a normal workweek of 30 or more hours. The term includes a sole proprietor, a business owner, including the owner of a farm business, a partner of a partnership and a member of a limited liability company if the sole proprietor, business owner, partner or member is included as an employe under a health benefit plan of a small employer, but the term does not include an employe who works on a temporary or substitute basis.

SECTION 97. 635.20 (2) of the statutes is amended to read:

635.20 **(2)** "Eligible small employer" means an employer that satisfies the requirements of s. 635.25 (1).

SECTION 98. 635.20 (13) of the statutes is repealed and recreated to read:

635.20 **(13)** "Small employer insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers group health benefit plans covering eligible employes of one or more small employers in this state, or that sells 3 or more individual health benefit plans to a small employer, covering eligible employes of the small employer. The term includes a health maintenance organization, as defined in s. 609.01 (2), a preferred provider plan, as defined in s. 609.01 (4), and an insurer operating as a cooperative association organized under ss. 185.981 to 185.985, but does not include a limited service health organization, as defined in s. 609.01 (3).

SECTION 99. 635.23 (1) (a), (d), (dp), (dr) and (e) (intro.), 1., 2. and 3. of the statutes are amended to read:

635.23 **(1)** (a) By rule determine the basic benefits that small employer insurers may offer to eligible small employers for providing coverage to eligible employes and their dependents.

(d) By rule establish small employer eligibility requirements for ~~participation in the plan~~ the purchase of a policy providing the basic benefits.

(dp) By rule determine whether small employers ~~participating in the plan~~ that purchase a policy providing the basic benefits may impose a probationary or waiting period on employes who become eligible for coverage after the commencement of the small employer's coverage. The plan board may not allow for a probationary or waiting period that exceeds 90 days.

(dr) By rule determine enrollment periods, if any, for small employer or employe coverage under the plan.

(e) (intro.) Annually submit a report ~~to the chief clerk of each house of the legislature, for distribution under s. 13.172 (3)~~ to the appropriate standing

committees~~,~~ under s. 13.172 (3) summarizing the activities of the plan board and the operation of the plan in the preceding year, and including but not limited to all of the following:

1. The number of small employers ~~participating in the plan~~ purchasing a policy providing the basic benefits.

2. The number of employes and dependents ~~participating in the plan~~ covered under a policy providing the basic benefits.

3. An evaluation of the plan's operation ~~and~~, effectiveness and availability.

SECTION 100. 635.23 (4) and (5) of the statutes are amended to read:

635.23 **(4)** In the formulation of the plan, for the purpose of cost containment the plan board shall encourage the use, to the extent possible, of the services of health care providers other than physicians. The plan board shall report any recommendations on ways to encourage the use of the services of health care providers other than physicians ~~to the chief clerk of each house of the legislature for distribution under s. 13.172 (3)~~ to the standing committees with jurisdiction over health insurance under s. 13.172 (3).

(5) The plan board may submit any recommendations for legislation to improve the plan ~~to the chief clerk of each house of the legislature for distribution under s. 13.172 (3)~~ to the standing committees with jurisdiction over health insurance under s. 13.172 (3).

SECTION 101. 635.25 (title) of the statutes is amended to read:

635.25 (title) **Eligibility ~~for participation in plan.~~**

SECTION 102. 635.25 (1) (a) (intro.) of the statutes is amended to read:

635.25 **(1)** (a) (intro.) To be eligible to ~~participate in the plan by purchasing~~ purchase a policy under this subchapter containing the basic benefits, an employer:

SECTION 103. 635.25 (1) (b) of the statutes is amended to read:

635.25 **(1)** (b) Except as provided in ss. 645.43 and 646.35, ~~an~~ a small employer that purchases a policy under this subchapter containing the basic benefits and that ceases to be eligible ~~to participate in the plan~~ during a policy period shall retain coverage under the ~~plan~~ policy to the end of the policy period.

SECTION 104. 635.25 (1m) of the statutes is amended to read:

635.25 **(1m)** Notwithstanding sub. (1), ~~an~~ a small employer is not eligible to ~~participate in the plan~~ purchase a policy under this subchapter containing the basic benefits if all of the individuals to be covered under the ~~plan~~ policy may be covered ~~by a single~~ under an individual policy providing ~~individual~~ single or family coverage.

SECTION 105. 635.25 (2) of the statutes is amended to read:

635.25 **(2)** EMPLOYES AND DEPENDENTS. (a) All eligible employes of an eligible small employer that ~~participates in the plan~~ purchases a policy under this subchapter are eligible for coverage under the ~~plan~~ policy, subject to the policy terms.

(b) Any dependent of an eligible employe who is covered under the ~~plan~~ policy is also eligible for coverage under the ~~plan~~ policy, subject to the policy terms.

SECTION 106. 635.254 of the statutes is amended to read:

635.254 Employer premium contribution. (1) ~~An~~ A small employer that ~~participates in the plan~~ purchases a policy under this subchapter shall pay a premium contribution of not less than 50% of the premium rate on behalf of an eligible employe with ~~individual~~ single coverage and not less than 40% of the premium rate on behalf of an eligible employe with family coverage.

(2) ~~An~~ A small employer under sub. (1) shall withhold from the earnings of an employe with coverage under the ~~plan~~ policy under this subchapter the amount of premium not contributed by the small employer under sub. (1).

(3) For an eligible employe who obtains coverage under the health insurance risk–sharing plan under s. 619.12 (2) (e) 2., ~~an~~ a small employer under sub. (1) shall pay a premium contribution to the health insurance risk–sharing plan that is equal to the amount that the small employer would pay on behalf of the employe for coverage under the ~~plan~~ policy under this subchapter.

SECTION 107. 635.26 of the statutes is repealed.

SECTION 108. 635.272 (1) of the statutes is amended to read:

635.272 **(1)** CONTRACTING HEALTH CARE PROVIDERS. A health care provider that contracts with a small employer insurer to provide services to individuals with coverage under ~~the plan~~ a policy under this subchapter shall accept amounts payable under the contract for ~~the basic~~ benefits under the policy as payment in full for those services. This subsection does not affect liability for deductibles or copayments.

SECTION 109. 635.28 of the statutes is amended to read:

635.28 Liability of state and plan board. Neither the state nor the plan board is liable for any obligation arising under the plan. Plan board members are immune from civil liability for acts or omissions ~~while performing~~ in the performance of their duties under this subchapter.

SECTION 110. 635.29 (title) of the statutes is repealed and recreated to read:

635.29 (title) **Applicability of health insurance mandates.**

SECTION 111. Nonstatutory provisions.

(1) RISK ADJUSTMENT COMMITTEE. The commissioner of insurance shall appoint a committee on risk adjustment under section 15.04 (1) (c) of the statutes, consisting of 5 to 8 members, to advise the commissioner on, and to assist the commissioner in developing rules for, the group risk adjustment mechanism under section 635.07 (4)

of the statutes, as affected by this act. The commissioner shall appoint at least 5 representatives of insurers to be members of the committee.

(2) RISK ADJUSTMENT MECHANISM EMERGENCY RULE–MAKING AUTHORITY. Using the procedure under section 227.24 of the statutes, the commissioner of insurance may promulgate rules under section 635.07 (4) (e) of the statutes, as affected by this act, for the period before the effective date of the permanent rules promulgated under section 635.07 (4) (e) of the statutes, as affected by this act, but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) and (3) of the statutes, the commissioner is not required to make a finding of emergency.

(3) HEALTH INSURANCE RISK–SHARING PLAN BOARD MEMBER TERMS.

(a) Notwithstanding section 15.07 (1) (c) of the statutes and section 619.15 (1) of the statutes, as affected by this act, the terms of the 7 appointed members currently serving on the board of governors of the health insurance risk–sharing plan shall expire on July 1, 1996.

(b) Notwithstanding section 619.15 (1) of the statutes, as affected by this act, the new members of the board of governors of the health insurance risk–sharing plan shall be appointed for the following terms:

1. One representative of an insurer, one representative of a health care provider and one public member, to be determined by the commissioner, for terms expiring on May 1, 1997.

2. One representative of an insurer, one representative of a health care provider and one public member, to be determined by the commissioner, for terms expiring on May 1, 1998.

3. One representative of an insurer, one representative of a health care provider and one public member, to be determined by the commissioner, for terms expiring on May 1, 1999.

(4) STUDY BY HEALTH INSURANCE RISK-SHARING PLAN BOARD.

(a) The board of governors of the health insurance risk–sharing plan shall study alternatives for reducing costs under the plan through the use of managed care plans. The board shall study at least all of the following:

1. The feasibility of including plan enrollees in the program administered by the department of health and social services that provides health care services to medical assistance recipients through managed care providers.

2. The development of a competitive bid process for the provision of covered services to plan enrollees. As part of this requirement, the board shall consider all of the following competitive bidding and pricing alternatives:

a. Fully capitated bids.

b. Bids under which the health insurance risk–sharing plan and the health care plan providing the covered services share the risk that costs will exceed a predetermined amount and the savings when costs are below a predetermined amount.

c. Bids under which only specified services are provided on a capitated basis.

d. Bids under which only identified groups of plan enrollees are covered on a capitated basis.

(b) The board shall submit a report of the results of the study and its recommendations to the legislature under section 13.172 (2) of the statutes no later than July 1, 1996.

(5) RULES ON HEALTH INSURANCE RISK-SHARING PLAN MANAGED CARE INITIATIVE. The board of governors of the health insurance risk–sharing plan shall submit in proposed form the rules required under section 619.145 (1m) of the statutes, as created by this act, to the legislative council staff under section 227.15 (1) of the statutes no later than January 1, 1997.

(6) STUDY ON ESTABLISHING A BASIC HEALTH INSURANCE PLAN.

(a) The department of health and social services and the office of the commissioner of insurance shall jointly study the establishment of a basic health insurance plan. The study shall include consideration of all of the following:

1. The feasibility of including coverage under the basic health insurance plan for different groups of people, including low–income persons, persons with coverage under the health insurance risk–sharing plan and recipients of medical assistance or health care benefits under another public assistance program.

2. The benefits to be provided under the basic health insurance plan.

3. A plan and a timetable for phasing out the imposition of surcharges under section 619.13 of the statutes, as affected by this act, for the health insurance risk–sharing plan and for replacing the lost revenues with other funds, including premiums collected for the basic health insurance plan or state or federal funds.

(b) The department of health and social services and the office of the commissioner of insurance shall submit a report of the study with their recommendations, addressing each of the items under paragraph (a), to the legislature under section 13.172 (2) of the statutes no later than January 1, 1997.

(7) EVALUATION OF MARKET REFORMS.

(a) The commissioner of insurance shall evaluate the effectiveness of the health insurance market reforms under chapter 635 of the statutes, as affected by this act, including the effectiveness of the reforms with respect to all of the following:

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

2. Availability of health insurance coverage for uninsured persons.

3. Affordability of health insurance coverage.

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

SECTION 112. Initial applicability.

(1) HEALTH INSURANCE MARKET REFORM. The treatment of sections 40.51 (8) and (8m), 111.70 (4) (o), 111.91 (2) (L), 120.13 (2) (g), 185.983 (1g), 625.12 (2), 628.34 (3) (a) and (b), 632.76 (2) (a), 632.896 (4), 635.01, 635.02, 635.03, 635.04, 635.05, 635.07, 635.09, 635.11 (intro.), (1) and (4), 635.13, 635.15, 635.16, 635.17, 635.18 (title), (1) (a) and (b), (2), (3), (4), (5), (6), (7) and (8), 635.20 (1c), (1m), (2) and (13), 635.23 (1) (a), (d), (dp), (dr) and (e) (intro.), 1., 2. and 3., (4) and (5), 635.25 (1) (a) (intro.) and (b), (1m) and (2), 635.254, 635.26, 635.272 (1) and 635.28 of the statutes, the renumbering of section 635.18 (1) of the statutes, the amendment of section 66.184 (1) of the statutes, the repeal and recreation of section 111.70 (1) (a) (by SECTION 14 of the statutes and the creation of section 60.23 (25) (h) and (i) of the statutes first apply to all of the following:

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

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

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

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

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

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

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

SECTION 113. Effective dates. This act takes effect on the day after publication, except as follows:

(1) HEALTH INSURANCE MARKET REFORM. The treatment of sections 40.51 (8) and (8m), 111.70 (4) (o), 111.91 (2) (L), 120.13 (2) (g), 185.983 (1g), 625.12 (2), 628.34 (3) (a) and (b), 632.76 (2) (a), 632.896 (4), 635.01, 635.02, 635.03, 635.04, 635.05, 635.07, 635.09, 635.11 (intro.), (1) and (4), 635.13, 635.15, 635.16, 635.17, 635.18 (title), (1) (a) and (b), (2), (3), (4), (5), (6), (7) and (8), 635.20 (1c), (1m), (2) and (13), 635.23 (1) (a), (d), (dp), (dr) and (e) (intro.), 1., 2. and 3., (4) and (5), 635.25 (title), (1) (a) (intro.) and (b), (1m) and (2), 635.254, 635.26, 635.272 (1), 635.28 and 635.29 (title) and chapter 635 (title) of the statutes, the renumbering of section 635.18 (1) of the statutes, the amendment of section 66.184 (1) of the statutes, the repeal and recreation of section 111.70 (1) (a) (by SECTION 15) of the statutes, the creation of

section 60.23 (25) (h) and (i) of the statutes and SECTION 112 of this act take effect on the first day of the 12th month beginning after publication.

(2) HEALTH INSURANCE RISK-SHARING PLAN SURCHARGE. The treatment of sections 619.14 (5) (d), 619.145 (1) and (1m), 619.15 (1) and 619.165 (1) (a) and (2) of the statutes, the repeal of sections 619.145 (3) (e) and (4) and 619.15 (4) (e) of the statutes, the renumbering of section 66.184 of the statutes, the renumbering and amendment of section 60.23 (25) of the statutes, the amendment of sections 111.70 (1) (a), 619.135 (2) and (3), 619.15 (3) (c) and 619.175 of the statutes, the repeal and recreation of sections 619.10 (3m) (by SECTION 27), 619.13 (by SECTION 29) and 619.15 (4) (c) (by SECTION 53) of the statutes and the creation of sections 40.51 (8c), 60.23 (25) (a), 66.184 (2), 111.70 (4) (n), 111.91 (2) (k), 120.13 (2) (gm) and 619.15 (3) (bc) and (bm) of the statutes take effect on July 1, 1996.

(3) INVALID SURCHARGE AND INSURER ASSESSMENT. The repeal of sections 40.51 (8c), 60.23 (25) (a), 66.184 (2), 111.70 (4) (n), 111.91 (2) (k), 120.13 (2) (gm) and 619.15 (3) (bc) and (bm) of the statutes, the repeal and recreation of sections 111.70 (1) (a) (by SECTION 16), 619.10 (3m) (by SECTION 28), 619.13 (by SECTION 30), 619.135 (2) (by SECTION 32) and (3) (by SECTION 35), 619.15 (3) (c) and (4) (c) (by SECTION 54) and 619.175 (by SECTION 62) of the statutes and the creation of sections 619.145 (3) (e) and (4) and 619.15 (4) (e) of the statutes take effect on the date on which the commissioner of insurance certifies to the revisor of statutes under section 619.13 (6) (b) of the statutes, as affected by this act, that the surcharge or its application is invalid with respect to all persons.

(4) HEALTH INSURANCE RISK-SHARING PLAN WAIVER OR EXEMPTION. The repeal and recreation of sections 619.135 (2) (by SECTION 33) and (3) (by SECTION 36) and 619.175 (by SECTION 63) of the statutes takes effect on the day after 2 years after the date on

which the commissioner of insurance certifies to the revisor of statutes under section 619.13 (6) (b) of the statutes, as affected by this act, that the surcharge or its application is invalid with respect to all persons.

(END)