State of Wisconsin
1995 - 1996 LEGISLATURE

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1995 ASSEMBLY BILL 416

May 30, 1995 - Introduced by Representatives UNDERHEIM, OURADA, URBAN, F. LASEE, ZIEGELBAUER, WASSERMAN, JOHNSRUD, KELSO, HUBER, HANDRICK, SPRINGER, GARD, LADWIG, BALDUS, ZUKOWSKI, SILBAUGH, HAHN, BOYLE, ALBERS, OTTE, AINSWORTH, OTT and FREESE, cosponsored by Senators ROSENZWEIG, RUDE and BUETTNER. Referred to Committee on Health.

AN ACT ***to repeal*** 635.02 (5m), 635.07 and 635.26 (1) (b); ***to renumber and amend*** 635.26 (1) (a); ***to amend*** 40.51 (8), 60.23 (25), 66.184, 111.70 (1) (a), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 600.01 (2) (b), 628.34 (3) (a), 628.34 (3) (b), 632.76 (2) (a) and 632.896 (4); ***to repeal and recreate*** 635.17; and ***to create*** 40.52 (1m), 111.70 (4) (m), 111.91 (2) (k), 632.745, 632.747 and 632.749 of the statutes; **relating to:** group health insurance market reform, including preexisting condition exclusions and limitations, guaranteed acceptance, portability and contract termination and renewability; and collective bargaining of certain health care coverage requirements.

Analysis by the Legislative Reference Bureau

HEALTH INSURANCE MARKET REFORM

Scope of reform

This bill imposes a number of general market reform requirements on insurers with respect to health benefit plans. A health benefit plan is defined in the bill as any hospital or medical policy or certificate, excluding conversion policies and such insurance policies as dental, vision, long-term care, medicare supplement, medicare replacement, worker's compensation, specified disease and automobile medical payment insurance policies. The market reform requirements apply to group health benefit plans sold to employers, including the state and municipalities, and to individual health benefit plans covering eligible employes (those who normally work 30 or more hours per week) when 3 or more are sold to an employer. Most requirements also apply to self-insured health plans of the state and municipalities.

Guaranteed issue; guaranteed acceptance

Under current law, an insurer that offers health benefit plan coverage to small employers (employers with 2 to 25 eligible employes) must offer coverage to all of a small employer's eligible employes. Such an insurer must issue a basic benefits plan to any small employer, covering all eligible employes, without regard to health condition or claims experience, if the small employer agrees to pay the premium and comply with all other plan provisions. The insurer must provide coverage under the basic benefits plan to any employe who becomes eligible for coverage after the commencement of the employer's coverage.

The bill provides that an insurer that offers group health benefit plan coverage to any employer (not only small employers) must offer coverage to all of the employer's eligible employes. Although such an insurer is not required under the bill to issue a group health benefit plan to any employer that applies for coverage (other than a basic benefits plan to any small employer that applies for a basic benefits plan), an insurer that does provide coverage to an employer group under a group health benefit plan must provide coverage under the plan to any employe who becomes eligible for coverage under the plan after the commencement of the employer's coverage. Additionally, such an insurer must provide coverage under the group health benefit plan to an eligible employe who waived coverage previously because he or she was covered as a dependent (usually as a spouse) under another health benefit plan, if the employe's coverage under the other health benefit plan was terminated not more than 30 days before the effective date of coverage under the group health benefit plan due to a divorce from the employe's spouse or due to the spouse's death or loss of coverage under the other health benefit plan. These requirements also apply to self–insured plans of the state or of municipalities.

Preexisting conditions and portability

Under current law a group health benefit plan issued to a small employer may not exclude or limit benefits on account of a preexisting condition for more than 12 months after the commencement of coverage and may not define a preexisting condition more restrictively than a pregnancy existing on the effective date of coverage or a condition for which the insured sought or should have sought medical care during the 6 months immediately preceding coverage. The bill expands these same requirements regarding preexisting condition exclusions and limitations to all group health benefit plans and to self–insured plans of the state or of municipalities.

Under current law, a group health benefit plan issued to a small employer must waive any period applicable to a preexisting–condition exclusion or limitation that was satisfied under another plan under which an insured had coverage that terminated not more than 30 days before the effective date of coverage under the new plan. Under the bill, group health benefit plans, including group plans sold to small employers, must waive any period applicable to a preexisting condition exclusion or limitation that was satisfied under another plan under which the insured had coverage that terminated 60 or fewer days before the effective date of coverage under the new plan. This requirement also applies to self–insured plans of the state or of municipalities.

Contract termination and renewability

Under the bill, a group health benefit plan may not be canceled before the expiration of the agreed term, and must be renewed at the option of the policyholder, except for such reasons as failure to pay a premium when due or fraud or misrepresentation. An insurer may elect not to renew a group health benefit plan only if the insurer thereafter ceases to issue or renew any group health benefit plans for a minimum of 5 years. These same contract termination and renewability provisions apply under current law to group health benefit plans that are issued to small employers.

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

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

SECTION 1. 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), 632.745, 632.747, 632.749, 632.87 (3) to (5), 632.895 (5m) and (8) to (10) and 632.896.

SECTION 2. 40.52 (1m) of the statutes is created to read:

40.52 **(1m)** The standard plan shall comply with ss. 632.745 (2), (3) and (5) (a) 2. and (b) 2. and 632.747 (3).

SECTION 3. 60.23 (25) of the statutes is amended to read:

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

SECTION 4. 66.184 of the statutes is amended to read:

66.184 Self–insured health plans. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employes on a self–insured basis, the

self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.745 (2), (3) and (5) (a) 2. and (b) 2., 632.747 (3), 632.87 (4) and (5), 632.895 (9) and (10), 632.896, 767.25 (4m) (d) and 767.51 (3m) (d).

SECTION 5. 111.70 (1) (a) of the statutes 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 representatives of its employes, 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 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 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 employes. In creating this subchapter the legislature recognizes that the public employer must exercise its powers and responsibilities to act for the government and good order of the municipality, 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 public employes by the constitutions of this state and of the United States and by this subchapter.

SECTION 6. 111.70 (4) (m) of the statutes is created to read:

111.70 **(4)** (m) *Health benefit plan requirements.* The municipal employer is prohibited from bargaining collectively with respect to compliance with the health benefit plan requirements under ss. 632.745, 632.747 and 632.479.

SECTION 7. 111.91 (2) (k) of the statutes is created to read:

111.91 **(2)** (k) Compliance with the health benefit plan requirements under ss. 632.745, 632.747 and 632.749.

SECTION 8. 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), 632.745 (2), (3) and (5) (a) 2. and (b) 2., 632.747 (3), 632.87 (4) and (5), 632.895 (9) and (10), 632.896, 767.25 (4m) (d) and 767.51 (3m) (d).

SECTION 9. 185.981 (4t) of the statutes is amended to read:

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

SECTION 10. 185.983 (1) (intro.) of the statutes is amended to read:

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

SECTION 11. 600.01 (2) (b) of the statutes is amended to read:

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

SECTION 12. 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 and 632.745. 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 13. 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. 632.745, 632.747, 632.749, 635.09 and 635.26.

SECTION 14. 632.745 of the statutes is created to read:

632.745 Coverage requirements for group health benefit plans. (1) GROUP HEALTH INSURANCE MARKET REFORM; DEFINITIONS. In this section and ss. 632.747 and 632.749:

(a) "Eligible employe" means an employe who works on a permanent basis and has a normal work week 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.

(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) "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, 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.

(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. 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).

(f) "Qualifying coverage" means benefits or coverage provided under any of the following:

1. Medicare or medicaid.

2. 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 under subch. II of ch. 635.

3. An individual health benefit plan that provides benefits similar to or exceeding benefits provided under a basic health benefit plan under subch. II of ch. 635, if the individual health benefit plan has been in effect for at least one year.

(g) "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 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. A group health benefit plan, or a self–insured health plan, may not define a preexisting condition more restrictively than any of the following:

(a) 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 coverage.

(b) 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) A pregnancy existing on the effective date of coverage.

(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 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.

(5) PROHIBITED COVERAGE PRACTICES. (a) 1. 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. 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. 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. 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.

(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.

SECTION 15. 632.747 of the statutes is created to read:

632.747 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 or 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 or 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 16. 632.749 of the statutes is created to read:

632.749 Contract termination and renewability. (1) MIDTERM CANCELLATION. Notwithstanding s. 631.36 (2) to (4m), a group 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 group 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) The number of individuals covered under the group health benefit plan is less than the number required by the group health benefit plan.

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

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

(a) The insurer ceases to renew all other group health benefit plans issued by the insurer.

(b) 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.

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

(d) 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 group health benefit plan if the insurer that issued the group health benefit plan is in liquidation.

SECTION 17. 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 group health benefit plan, as defined in s. 632.745 (1) (c), which is subject to s. 632.745 (2).

SECTION 18. 632.896 (4) of the statutes is amended to read:

632.896 **(4)** PREEXISTING CONDITIONS. Notwithstanding ~~s.~~ ss. 632.745 (2) and 632.76 (2) (a), 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 19. 635.02 (5m) of the statutes is repealed.

SECTION 20. 635.07 of the statutes is repealed.

SECTION 21. 635.17 of the statutes is repealed.

SECTION 22. 635.26 (1) (a) of the statutes is renumbered 635.26 (1).

SECTION 23. 635.26 (1) (b) of the statutes is repealed.

SECTION 24. Initial applicability.

(1) This act first applies to group health benefit plans that are issued or renewed, and to self–insured health plans that are extended, modified or renewed

under collective bargaining agreements, on the first day of the 12th month beginning after publication.

SECTION 25. Effective date.

(1) This act takes effect on the first day of the 12th month beginning after publication.

(END)