State of Wisconsin
1995 - 1996 LEGISLATURE

LRB-2852/1
PJK:kmg:kaf

1995 ASSEMBLY BILL 394

May 24, 1995 - Introduced by Representatives ROBSON, KUNICKI, BALDUS, BELL, BLACK, BOCK, BOYLE, CARPENTER, COGGS, GROBSCHMIDT, HANSON, HUBER, MORRIS-TATUM, NOTESTEIN, PLACHE, PLOMBON, R. POTTER, SPRINGER, VANDER LOOP, WIRCH, L. YOUNG, R. YOUNG and HASENOHRL, cosponsored by Senators MOEN, CLAUSING and BURKE. Referred to Committee on Health.

AN ACT ***to repeal*** subchapter I of chapter 635 [precedes 635.01.], subchapter II (title) of chapter 635 [precedes 635.20] and 635.26 (1s); ***to amend*** 15.735 (1), 111.70 (1) (a), 185.981 (4t), 185.983 (1) (intro.), 185.983 (1g), 600.01 (2) (b), 619.12 (1) (intro.), 619.12 (2) (e) 2. (intro.), 619.12 (2) (e) 2. b., 625.03 (6), 625.12 (2), 625.15 (1), 625.22 (1), 625.22 (4), 628.36 (2) (b) 1., 3. and 5., 631.01 (4), 632.70, 632.76 (2) (a), 632.896 (4), 632.897 (2) (d), 632.897 (9) (c), chapter 635 (title), 635.20 (intro.), 635.20 (10), 635.25 (1) (a) (intro.), 635.25 (1) (b), 635.25 (1m), 635.254 (1), 635.254 (3), 635.28, 635.29, 635.31 and 646.35 (5); ***to repeal and recreate*** 635.20 (1c), 635.20 (1m) and 635.20 (13); and ***to create*** 20.145 (1) (h), 111.70 (4) (m), 601.424, 628.34 (3) (c), 632.727, 632.745, 632.746, 632.7465, 632.747, 632.748, 632.749 and 632.83 of the statutes; **relating to:** health insurance market reform, granting rule-making authority and making an appropriation.

Analysis by the Legislative Reference Bureau

HEALTH INSURANCE MARKET REFORM

Scope of reform

This bill imposes a number of general requirements on insurers with respect to individual and group health benefit plans that are issued or renewed on or after

October 1, 1996. A health benefit plan is defined in the bill as any hospital or medical policy or certificate, including a conversion health insurance policy, but excluding such insurance policies as dental, vision, long–term care, medicare supplement, medicare replacement, worker's compensation, specified disease, health insurance risk–sharing plan and automobile medical payment insurance policies.

Community rating

All health benefit plans must be community rated. The community rates, however, may be modified by the insured's age and gender and by whether the insured's coverage is single or a type of family. The commissioner of insurance (commissioner) must by rule define "community" for the purpose of determining community rates. A "community" may not be a geographical area that includes less than an entire county or federal metropolitan statistical area, whichever is larger. The commissioner must by rule prescribe rate bands for the modifications and may also by rule prescribe rate restrictions that provide for a transition to the modified community rates.

Guaranteed issue

With certain specified exceptions, an insurer that has in force a health benefit plan must issue a group health benefit plan to an employer that agrees to pay the premium and comply with all other plan provisions, and to all of the employer's employes with a normal work week of 30 or more hours and any of the employer's other employes for whom the employer desires to provide coverage, including employes who become eligible for coverage after the commencement of the employer's coverage, without regard to health condition or claims experience. Such an insurer is also required to issue an individual health benefit plan to an individual who agrees to pay the premium and comply with all other plan provisions, without regard to health condition or claims experience. An insurer, however, may limit its issuance of health benefit plans to group plans, and related individual conversion policies, for employers with 2 to 25 employes, group plans, and related individual conversion policies, for employers with more than 25 employes or individual plans.

Reinsurance

The bill requires the commissioner to establish a risk adjustment mechanism by rule for insurers issuing health benefit plans. The rules must define "high–risk medical conditions", determine the percentage of individuals with coverage under all health benefit plans who have high–risk medical conditions and provide for an assessment against each insurer that insures a lower percentage of individuals with high–risk medical conditions than the overall percentage and a reimbursement for each insurer that insures a higher percentage of individuals with high–risk medical conditions than the overall percentage. The commissioner must establish an advisory committee to advise the commissioner on the contents of the rules and to review the rules and make recommendations on them to the legislature. The committee members are to be appointed by the commissioner and must be, in addition to the commissioner, representatives of insurers, including a health maintenance organization; 2 actuaries; 2 underwriters; and a medical director.

Preexisting conditions and portability

Under current law a group health benefit plan issued to an employer with 2 to 25 employes 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. Additionally, such a plan must waive any period applicable to a preexisting condition exclusion or limitation that was satisfied under another plan under which the insured had coverage to a date not more than 30 days before the effective date of coverage under the new plan.

Under the bill, except for a conversion health insurance policy, which under current law may not impose any preexisting condition limitations or exclusions, a group or an individual health benefit plan may not exclude or limit benefits on account of a preexisting condition for more than 12 months, as under current law. A group or individual health benefit plan may not define a preexisting condition more restrictively than a pregnancy existing on the effective date of coverage, except that coverage may not be excluded for covered prenatal care expenses or for other covered expenses for such a pregnancy that exceed a separate deductible amount prescribed by the commissioner by rule. Additionally, a group health benefit plan may not define a preexisting condition more restrictively than a condition for which the insured sought or should have sought medical care during the 6 months immediately preceding coverage, and an individual plan may not define a preexisting condition more restrictively than a condition for which the insured sought or should have sought medical care during the 12 months immediately preceding coverage. An individual who is a resident or an employe who has satisfied any necessary waiting period may obtain coverage under a group or individual health benefit plan without any preexisting condition exclusion or limitation if the individual, employer or employe applies for coverage during the 45–day period beginning on October 1, 1996, within 30 days after the later of the date on which the individual or employe becomes 18 years old or the date on which the individual's or employe's coverage under a health benefit plan as a dependent ceases or during a biennial 30–day open enrollment period specified by the commissioner by rule. Both group and individual health benefit plans must waive any period applicable to a preexisting condition exclusion or limitation that was satisfied under another plan, including the health insurance risk–sharing plan (HIRSP), under which coverage terminated not more than 60 days before the effective date of coverage under the new plan.

Contract renewability and fair marketing standards

A 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 health benefit plan only if the insurer thereafter ceases to issue or renew any health benefit plans for a minimum of 5 years.

Insurers that offer health benefit plans must actively market such health benefit plans and are prohibited from such marketing practices as discouraging an

employer or individual from applying for coverage, or encouraging an employer or individual to seek coverage from a different insurer, for reasons related to health condition, claims experience or other characteristics of the employer or individual.

These contract renewability and fair marketing provisions apply under current law to group health benefit plans that are issued to an employer with 2 to 25 employes.

OTHER

Electronic claims

The bill requires every insurer that offers health insurance (called disability insurance in the statutes) to accept all claims electronically and to allow electronic access to eligibility and claims status information. Insurers must have this capability and use it beginning on January 1, 1996. Also beginning on that date, health care providers that have annual gross revenues of more than $1,000,000 must be able to transmit health insurance claims electronically. All other health care providers must have and use this capability beginning on January 1, 1998.

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. 15.735 (1) of the statutes is amended to read:

15.735 **(1)** SMALL EMPLOYER INSURANCE BOARD. There is created a small employer insurance board which is attached to the office of the commissioner of insurance under s. 15.03. The board shall consist of 11 members. Notwithstanding s. 15.07 (2) (intro.), one member shall be the commissioner of insurance, or his or her designee, who shall be a nonvoting member and who shall serve permanently as chairperson of the board. The other 10 members shall be nominated by the governor, and with the advice and consent of the senate appointed, for 3–year terms. Five members shall represent employers that are eligible to participate in the plan under ~~subch. II of~~ ch. 635, and 5 members shall represent employes of employers that are eligible to participate in the plan under ~~subch. II of~~ ch. 635.

SECTION 2. 20.145 (1) (h) of the statutes is created to read:

20.145 **(1)** (h) *Risk adjustment mechanism.* All moneys received from risk adjustment assessments against health insurers for risk adjustment reimbursements to health insurers under rules promulgated under s. 632.747 (4).

SECTION 3. 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 4. 111.70 (4) (m) of the statutes is created to read:

111.70 **(4)** (m) *Health insurance market reform requirements.* A municipal employer that is an employer under the definition specified in s. 632.745 (1) (b) 2. is prohibited from bargaining collectively with respect to the health insurance requirements under ss. 632.745 to 632.749.

SECTION 5. 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 to 632.749, 632.87 (2m), (3), (4) and (5), 632.895 (10) and 632.897 (10) and ch. 155.

SECTION 6. 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 to 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 7. 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 8. 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 ss. 632.745 to 632.749 or ch. 633 or 635.

SECTION 9. 601.424 of the statutes is created to read:

601.424 Reports on market reform impact on the health insurance risk–sharing plan. The commissioner shall study the effects of the health insurance market reforms under ss. 632.745 to 632.749 on enrollment under, and other aspects of, the health insurance risk–sharing plan under subch. II of ch. 619. The commissioner shall annually submit a report on the effects and any recommendations to the legislature under s. 13.172 (2) commencing on October 1, 1997.

SECTION 10. 619.12 (1) (intro.) of the statutes is amended to read:

619.12 **(1)** (intro.) Except as provided in subs. (1m) ~~and (2)~~ to (3), the board or administering carrier shall certify as eligible a person who is covered by medicare because he or she is disabled under 42 USC 423, a person who submits evidence that he or she has tested positive for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV, and any person who receives and submits any of the following based wholly or partially on medical underwriting considerations within 9 months prior to making application for coverage by the plan:

SECTION 11. 619.12 (2) (e) 2. (intro.) of the statutes is amended to read:

619.12 **(2)** (e) 2. (intro.) Subdivision 1 does not apply to a person who is eligible for health care benefits under the small employer health insurance plan under ~~subch. II of~~ ch. 635 if all of the following apply:

SECTION 12. 619.12 (2) (e) 2. b. of the statutes is amended to read:

619.12 **(2)** (e) 2. b. The board determines that the coverage under the small employer health insurance plan under ~~subch. II of~~ ch. 635 is not substantially equivalent to or greater than the coverage under the plan.

SECTION 13. 625.03 (6) of the statutes is amended to read:

625.03 **(6)** Group and blanket accident and sickness insurance other than credit accident and sickness insurance, except as provided in s. 625.22 with regard to s. 632.746 and any rules promulgated under s. 632.7465.

SECTION 14. 625.12 (2) of the statutes is amended to read:

625.12 **(2)** CLASSIFICATION. ~~Risks~~ Subject to s. 632.746 and any rules promulgated under s. 632.7465, risks may be classified in any reasonable way for the establishment of rates and minimum premiums, except that no such 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 632.746 and any rules promulgated under s. 632.7465, 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 15. 625.15 (1) of the statutes is amended to read:

625.15 **(1)** RATE MAKING. An insurer may itself establish rates and supplementary rate information for one or more market segments based on the factors in s. 625.12 and~~,~~ subject to s. 632.365 if the rates are for motor vehicle liability insurance~~, subject to s. 632.365,~~ or s. 632.746 and any rules promulgated under s. 632.7465 if the rates are for health benefit plans, as defined in s. 632.745 (1) (d). In the alternative, the insurer may use rates and supplementary rate information prepared by a rate service organization, with average expense factors determined by the rate service organization or with such modification for its own expense and loss experience as the credibility of that experience allows.

SECTION 16. 625.22 (1) of the statutes is amended to read:

625.22 **(1)** ORDER IN EVENT OF VIOLATION. If the commissioner finds after a hearing that a rate is not in compliance with s. 625.11 or 632.746 or rules promulgated under s. 632.7465, the commissioner shall order that its use be discontinued for any policy issued or renewed after a date specified in the order.

SECTION 17. 625.22 (4) of the statutes is amended to read:

625.22 **(4)** INTERIM RATES. Whenever an insurer has no legally effective rates as a result of the commissioner's disapproval of rates or other act, the commissioner shall on request specify interim rates for the insurer that are high enough to protect the interests of all parties, and that comply with s. 632.746 and any rules promulgated under s. 632.7465 if the rates are for health benefit plans, as defined in s. 632.745 (1) (d), and may order that a specified portion of the premiums be placed in an escrow account approved by the commissioner. When new rates become legally effective, the commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are trifling shall not be required.

SECTION 18. 628.34 (3) (c) of the statutes is created to read:

628.34 **(3)** (c) Paragraphs (a) and (b) do not apply to coverage under a health benefit plan, as defined in s. 632.745 (1) (d), which is subject to ss. 632.745 to 632.749.

SECTION 19. 628.36 (2) (b) 1., 3. and 5. of the statutes are amended to read:

628.36 **(2)** (b) 1. Except for health maintenance organizations, preferred provider plans, limited service health organizations and the small employer health insurance plan under ~~subch. II of~~ ch. 635, no health care plan may prevent any person covered under the plan from choosing freely among providers who have agreed to participate in the plan and abide by its terms, except by requiring the person covered to select primary providers to be used when reasonably possible.

3. Except as provided in subd. 4., no provider may be denied the opportunity to participate in a health care plan, other than a health maintenance organization, a limited service health organization, a preferred provider plan or the small employer health insurance plan under ~~subch. II of~~ ch. 635, under the terms of the plan.

5. Except for the small employer health insurance plan under ~~subch. II of~~ ch. 635 to the extent determined by the small employer insurance board under s. 635.23 (1) (b), all health care plans, including health maintenance organizations, limited service health organizations and preferred provider plans are subject to s. 632.87 (3).

SECTION 20. 631.01 (4) of the statutes is amended to read:

631.01 **(4)** GROUP POLICIES AND ANNUITIES FOR ELEEMOSYNARY INSTITUTIONS. This chapter, ch. 632 and the health insurance mandates under ch. 632 that apply to the plan under ~~subch. II of~~ ch. 635 do not apply to group policies or annuities provided on a basis as uniform nationally as state statutes permit to educational, scientific research, religious or charitable institutions organized without profit to any person, for the benefit of employes of such institutions. The commissioner may by order subject such contracts issued by a particular insurer to this chapter, ch. 632 or the health insurance mandates under ch. 632 that apply to the plan under ~~subch. II of~~ ch. 635 or any portion of those provisions upon a finding, after a hearing, that the interests of Wisconsin insureds or creditors or the public of this state so require.

SECTION 21. 632.70 of the statutes is amended to read:

632.70 Exemption for plan under ch. 635. The health insurance mandates, as defined in s. 601.423 (1), that are provided under this subchapter apply to the small employer health insurance plan under ~~subch. II of~~ ch. 635 only to the extent determined by the small employer insurance board under s. 635.23 (1) (b).

SECTION 22. 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).

(2) INSURERS. Beginning on January 1, 1996, every insurer that offers disability insurance must have and use the capability to accept all claims electronically and to allow electronic access to information on eligibility, claim status and remittance advice.

(3) HEALTH CARE PROVIDERS. (a) Beginning on January 1, 1996, 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 23. 632.745 of the statutes is created to read:

632.745 Coverage requirements for health benefit plans. (1) HEALTH INSURANCE MARKET REFORM; DEFINITIONS. In ss. 632.745 to 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, a member of a limited liability company and an independent contractor if the sole proprietor, business owner, partner, member or independent contractor 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).

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

(d) "Health benefit plan" means any hospital or medical policy or certificate, and includes a conversion health insurance policy. "Health benefit plan" does not include accident–only, credit, dental, vision, medicare supplement, medicare replacement, long–term care, or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance, 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, 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, but does not include a limited service health organization, as defined in s. 609.01 (3).

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

1. Medicare or medicaid.

2. An employer–based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under a small employer health insurance plan under ch. 635.

3. An individual health insurance policy that provides benefits similar to or exceeding benefits provided under a small employer health insurance plan under ch. 635, if the policy has been in effect for at least one year.

4. The health insurance risk–sharing plan or an alternative plan under subch. II of ch. 619.

(f) "Resident" means a person who has maintained his or her place of permanent abode in this state for a period of 180 days immediately preceding his or her application for coverage under a health benefit plan. Domiciliary intent is required to establish that a person is maintaining his or her place of permanent abode in this state. Mere ownership of property is not sufficient to establish domiciliary intent. Evidence of domiciliary intent includes, without limitation, the location where the person votes, pays personal income taxes or obtains a driver's license.

(g) "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.

(h) "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) UNDERWRITING, PORTABILITY AND PREEXISTING CONDITIONS. (a) A group or 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. A health benefit plan may not define a preexisting condition more restrictively than any of the following:

1. a. With respect to a group health benefit plan, 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.

b. With respect to an individual health benefit plan, a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the 12 months immediately preceding the effective date of coverage and for which the individual did not seek medical advice, diagnosis, care or treatment.

2. a. With respect to a group health benefit plan, 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.

b. With respect to an individual health benefit plan, a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the effective date of coverage.

3. With respect to a group or individual health benefit plan, a pregnancy existing on the effective date of coverage, except that coverage may not be excluded

for any covered prenatal care expenses related to such a pregnancy or for other covered expenses related to such a pregnancy that exceed the deductible amount prescribed by the commissioner under par. (ac). Coverage not excluded may be subject to any deductibles or copayments that apply generally under the policy.

(ac) The commissioner shall by rule prescribe a separate deductible for covered expenses related to a pregnancy existing on the effective date of coverage, excluding covered prenatal care expenses. The rule shall provide for a sliding scale deductible that does not exceed $5,000 and that is determined on the basis of the stage of the pregnancy on the effective date of the coverage, so that the deductible is lower if coverage is obtained early in the pregnancy and higher if coverage is obtained late in the pregnancy.

(am) Notwithstanding par. (a), a group or individual health benefit plan may not deny, exclude or limit benefits for a covered individual who is a resident or for a covered employe who has satisfied any waiting period imposed by his or her employer or for any of the covered dependents of the individual or employe for losses due to a preexisting condition if the individual, employe or employe's employer applies for coverage:

1. During the 45–day period beginning on October 1, 1996.

2. Within 30 days after the later of the following:

a. The date on which the individual or employe becomes 18 years of age.

b. The date on which the individual's or employe's coverage as a dependent under a health benefit plan ceases.

3. During a 30–day enrollment period specified by the commissioner by rule under par. (ar).

(ar) The commissioner shall by rule specify a biennial 30–day enrollment period during which an individual or employe may obtain coverage under a group or individual health benefit plan without any preexisting condition exclusion or limitation.

(aw) An individual or employe may obtain coverage without a preexisting condition exclusion or limitation under par. (am) only once every 10 years.

(b) 1. A group or individual health benefit 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.

2. Subdivision 1. does not prohibit the application of a waiting period to all new enrollees under a health benefit plan issued to an employer; however, a waiting period may not be counted when determining whether the qualifying coverage terminated not more than 60 days before the effective date of the new coverage. For the purpose of subd. 1., the new coverage shall be considered effective as of the date that it would be effective but for the waiting period.

(c) This subsection does not apply to a conversion health insurance policy, which is subject to s. 632.897 (4) (a).

(3) MINIMUM PARTICIPATION OF EMPLOYES. (a) Except as provided in par. (d), requirements used by an insurer in determining whether to provide coverage 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 and that have the same number of eligible employes.

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

(c) 1. Except as provided in subd. 2., in applying minimum participation requirements with respect to an employer, an insurer may not count eligible employes or their dependents who have other coverage that is qualifying coverage in determining whether the applicable percentage of participation is met.

2. If an employer has 10 or fewer eligible employes, an insurer may count eligible employes or their dependents who have coverage under another health benefit plan sponsored by that employer in applying minimum participation requirements to determine whether the applicable percentage of participation is met.

(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.

SECTION 24. 632.746 of the statutes is created to read:

632.746 Community rating. (1) DEFINITIONS. In this section:

(a) "Community rate" means a uniform rate charged by an insurer that is determined in such a manner that all insured individuals with the same level of coverage and plan design in the same community, as that term is defined by the commissioner by rule under sub. (6), pay the same rate for that coverage without regard to claims experience, health condition, duration of coverage or such

demographic, actuarially based characteristics as age, gender, occupation or geographic area within the insured individual's community.

(b) "Federal metropolitan statistical area" means an area defined by the federal office of management and budget under 44 USC 3504 (d) (3) as a metropolitan statistical area or a primary metropolitan statistical area.

(c) "Trade association" means an association or other organization of businesses or of a profession or trade that is solely organized and controlled by, and solely operated for the benefit of, the members of the association or other organization and that sponsors a health benefit plan that covers at least 500 residents who are either members of the association or other organization or employes of at least 3 different employers that are members of the association or organization.

(2) MANDATORY USE. (a) Except as provided in par. (b) and sub. (3), an insurer shall charge a community rate for coverage under a health benefit plan that is issued or renewed on or after October 1, 1996.

(b) Subject to rate bands prescribed by the commissioner by rule, an insurer may modify the community rate under par. (a) by taking into account any of the following factors:

1. The insured's age.

2. Whether the insured's coverage is single or a type of family coverage.

3. The insured's gender.

(bm) For each of the following factors, the rate bands prescribed by the commissioner by rule shall restrict the ratio of the highest variance to the lowest variance to a ratio that is not more than the ratio shown after each factor:

(a) For age, a ratio of 2.5.

(b) For gender, a ratio of 1.2.

(c) If an insurer raises a community rate for a health benefit plan, the insurer shall raise all community rates for that health benefit plan and for all other health benefit plans offered by the insurer by the same percentage.

(3) TRADE ASSOCIATION RATE REDUCTIONS. (a) For a health benefit plan issued to a trade association, the commissioner may allow an insurer to reduce the community rate required under sub. (2) (a) and modifiable under sub. (2) (b) if the commissioner determines that a rate reduction is justified because of a reduction in the cost of coverage due to functions performed by the trade association, such as administrative or managed care functions.

(b) A trade association may submit an application for a rate reduction under par. (a) for a health benefit plan that it sponsors. The commissioner shall review the application and approve or disapprove a complete application within 30 days after it is received. The commissioner shall allow a rate reduction of up to 20% under par. (a) if the trade association establishes that it performs one or more material functions with respect to the health benefit plan that it sponsors.

(c) The commissioner may by rule or order exclude any trade association or category or class of trade associations from the application of pars. (a) and (b) if the commissioner determines that the trade association or category or class of trade associations is organized for a purpose that is inconsistent with the purposes of this chapter.

(4) RATE SERVICE ORGANIZATIONS. If an insurer uses rates for health benefit plans that are prepared by a rate service organization designated under s. 625.15, rates filed by the rate service organization on behalf of the insurer shall comply with this section.

(5) CERTIFICATION OF COMPLIANCE. An insurer that issues or renews a health benefit plan on or after October 1, 1996, 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:

(a) That the insurer is in compliance with the rate provisions of this section.

(b) That the 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 insurer's records and a review of the insurer's actuarial assumptions and statistical methods used in setting rates and procedures used in implementing rating plans.

(6) COMMISSIONER DEFINES COMMUNITY. The commissioner shall by rule define "community" for purposes of the definition of "community rate" under sub. (1) (a). The commissioner may not define "community" as a geographical area that includes less than an entire federal metropolitan statistical area or an entire county, whichever is larger.

SECTION 25. 632.7465 of the statutes is created to read:

632.7465 Transition by rule. Notwithstanding s. 632.746 (1) and (2), the commissioner may promulgate rules that permit an insurer to vary from the community rate required under s. 632.746 (2) (a) and modified under s. 632.746 (2) (b) within restrictions provided in the rules. The restrictions provided in the rules shall be reasonably designed to provide for an orderly transition to the community rates required under s. 632.746 (2) (a) and modified under s. 632.746 (2) (b) by no later than October 1, 1997.

SECTION 26. 632.747 of the statutes is created to read:

632.747 Guaranteed issue. (1) GROUP HEALTH BENEFIT PLANS. (a) Except as provided in sub. (3), an insurer shall provide coverage under a group health benefit plan to an employer, to all of the employer's eligible employes and their dependents, and to any of the employer's other employes for whom the employer desires to provide coverage and their dependents, regardless of health condition or claims experience, if all of the following apply:

1. The insurer has in force a health benefit plan.

2. The employer group meets the insurer's minimum participation requirements.

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

4. 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.

(b) An insurer shall provide coverage under a group health benefit plan to an eligible employe, or to any other employe for whom the employer desires to provide coverage, who becomes eligible for coverage according to the employer's requirements after the commencement of the employer's coverage, and to the eligible or other employe's dependents, regardless of health condition or claims experience.

(2) INDIVIDUAL HEALTH BENEFIT PLANS. Except as provided in sub. (3) and notwithstanding s. 632.897 (4) (d), an insurer shall provide coverage under an individual health benefit plan to an individual who is a resident and to the individual's dependents, regardless of health condition or claims experience, if all of the following apply:

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

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

(c) 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.

(3) EXCEPTIONS TO GUARANTEED ISSUE. (a) An insurer that is otherwise required to provide coverage under sub. (1) 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 an individual health benefit plan providing single or family coverage.

(b) An insurer that is otherwise required to provide coverage under sub. (2) may refuse to provide coverage to an individual if the individual was excluded from coverage under an employer's health benefit plan or self–funded health care plan for reasons related to the individual's health condition.

(c) An insurer that is otherwise required to provide coverage under sub. (2) may refuse to provide coverage to an individual if the individual waived coverage under an employer's health benefit plan or self–funded health care plan for reasons related to the individual's health condition.

(d) 1. In this paragraph, "municipal" means county, city, village, town or school district.

2. Subsections (1) and (2) do 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 if the insurer is authorized under its bylaws, charter or certificate of incorporation or authority to issue coverage only to state or municipal employes and former employes and their dependents.

(e) 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 subs. (1) and (2) to that single category or those limited categories of employers.

(f) The commissioner may exempt an insurer from the requirements of sub. (1) or (2) if the commissioner determines that any of the following applies:

1. It is inequitable to apply sub. (1) or (2) to the insurer due to its disproportionate share of groups or individuals with high claims experience.

2. It is in the public interest to exempt the insurer from the requirements under sub. (1) or (2) because the insurer is in financially hazardous condition.

(g) An insurer may limit its issuance of health benefit plans under subs. (1) and (2) to any of the following:

1. Group health benefit plans, and related individual conversion policies, to small employer groups.

2. Group health benefit plans, and related individual conversion policies, to employer groups that are not small employer groups.

3. Individual health benefit plans.

(4) RISK ADJUSTMENT; RULES. (a) The commissioner shall promulgate rules establishing a risk adjustment mechanism for insurers issuing health benefit plans under this section.

(b) The rules promulgated under par. (a) shall do all of the following:

1. Define "high–risk medical conditions", using diagnostic criteria and other criteria.

2. Place a dollar value on each high–risk medical condition based on the severity of the condition.

3. Determine the percentage of individuals with high–risk medical conditions covered by health benefit plans.

4. Provide for an annual assessment against each insurer insuring a lower percentage of individuals with high–risk medical conditions than the percentage established under subd. 3. Any moneys received from assessments imposed under the rules promulgated under this subdivision shall be credited to the appropriation under s. 20.145 (1) (h).

5. Provide for an annual reimbursement for each insurer insuring a higher percentage of individuals with high–risk medical conditions than the percentage established under subd. 3.

(5) ADVISORY COMMITTEE. (a) The commissioner shall establish and appoint the members of an advisory committee to advise the commissioner on the contents of the rules to be promulgated under sub. (4) including definitions, assessments and reimbursements. The committee shall also review the rules developed under sub. (4) and submitted to the legislature under s. 227.19 (2) and make recommendations to the legislature on the rules.

(b) The advisory committee established by the commissioner under par. (a) shall consist of the commissioner or his or her designee and all of the following:

1. A representative of an insurer that issues individual health benefit plans.

2. A representative of an insurer that issues group health benefit plans.

3. A representative of a health maintenance organization.

4. Two actuaries who are fellows of the American Academy of Actuaries.

5. An underwriter employed by an insurer that issues individual health benefit plans.

6. An underwriter employed by an insurer that issues group health benefit plans.

7. A medical director.

SECTION 27. 632.748 of the statutes is created to read:

632.748 Contract termination and renewability. (1) 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) The number of individuals covered under the health benefit plan is less than the number required by the health benefit plan.

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

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

(a) The insurer ceases to renew all other 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 not later than one year before termination of coverage.

(c) The insurer does not issue a health benefit plan earlier than 5 years after the nonrenewal of the 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 health benefit plan if the insurer that issued the health benefit plan is in liquidation.

SECTION 28. 632.749 of the statutes is created to read:

632.749 Fair marketing standards. (1) ACTIVE MARKETING. Every insurer shall actively market health benefit plan coverage to employers and individuals in this state.

(2) PROHIBITIONS RELATED TO CASE CHARACTERISTICS. (a) 1. Except as provided in subd. 2., an insurer or an intermediary may not directly or indirectly do any of the following:

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

b. Encourage or direct an employer or an individual to seek coverage from another insurer because of the health condition, claims experience, industry, occupation or geographic area of the employer or individual.

2. Subdivision 1. does not prohibit an insurer or an intermediary from providing an employer or an individual with information about an established geographic service area or a restricted network provision of the insurer.

(b) 1. Except as provided in subd. 2., 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 the intermediary for the sale of a health benefit plan that varies according to the health condition, claims experience, industry, occupation or geographic area of an employer, any of the employer's covered employes, an insured individual or any dependents.

2. Payment of compensation on the basis of percentage of premium is not a violation of subd. 1. if the percentage does not vary based on the health condition, claims experience, industry, occupation or geographic area of an employer, any of the employer's covered employes, an insured individual or any dependents.

(c) 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 condition, claims experience, industry, occupation or geographic area of the employers, covered employes, insured individuals or dependents placed by the intermediary with the insurer.

(3) PROHIBITION RELATED TO EXCLUDING EMPLOYE. An insurer or an intermediary may not induce or otherwise encourage an employer to separate or otherwise exclude an employe from health coverage or benefits provided in connection with the employe's employment.

(4) WRITTEN DENIAL REQUIRED. Denial by an insurer of an application for coverage from an employer shall be in writing and shall state the reason or reasons for the denial.

(5) THIRD–PARTY ADMINISTRATORS. A 3rd–party administrator that enters into a contract, agreement or other arrangement with an insurer to provide administrative, marketing or other services related to the offering of health benefit

plans to employers or individuals in this state is subject to this section as if it were an insurer.

(6) INSURER CEASING TO ISSUE. (a) An insurer that has in force one or more health benefit plans that are included in a category under s. 632.747 (3) (g) 1. to 3. shall actively market and issue health benefit plans in that category, as provided in s. 632.747, unless the insurer complies with all of the following:

1. Files notice with the commissioner that the insurer is ceasing to issue health benefit plans in that category.

2. Ceases to issue health benefit plans in that category for not less than 5 years.

3. Does not commence marketing or issuing health benefit plans in that category until the insurer files notice with the commissioner that the insurer intends to market and issue such health benefit plans.

(b) An insurer may not cease to actively market or issue health benefit plans in all categories under s. 632.747 (3) (g) 1. to 3. unless the insurer complies with s. 632.748 (2).

(7) ADDITIONAL STANDARDS BY RULE. The commissioner may by rule establish additional standards to provide for the fair marketing and broad availability of health benefit plans to employers and individuals in this state.

SECTION 29. 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. 632.745 (1) (d), which is subject to s. 632.745.

SECTION 30. 632.83 of the statutes is created to read:

632.83 Regulation of certain related policies. The commissioner may by rule prescribe standards for specified disease policies, hospital indemnity policies, as defined in s. 632.895 (1) (c), or limited benefit health policies, including prohibiting certain specified types of products, prescribing minimum coverage and establishing marketing or suitability standards.

SECTION 31. 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 32. 632.897 (2) (d) of the statutes is amended to read:

632.897 **(2)** (d) If the employer is notified to terminate the coverage for any of the reasons provided under par. (b), the employer shall provide the terminated insured written notification of the right to continue group coverage or convert to individual coverage and the payment amounts required for either continued or converted coverage including the manner, place and time in which the payments shall be made. This notice shall be given not more than 5 days after the employer receives notice to terminate coverage. The payment amount for continued group coverage may not exceed the group rate in effect for a group member, including an employer's contribution, if any, for a group policy as defined in sub. (1) (c) 1. or 1m. or the equivalent value of the monthly contribution of a group member to a group policy as defined in sub. (1) (c) 2. or the equivalent value of the monthly premium for

franchise insurance as defined in sub. (1) (c) 3. The premium for converted coverage shall be determined in accordance with the insurer's table of premium rates applicable to ~~the age and class of risks of~~ each person to be covered under that policy and to the type and amount of coverage provided, subject to s. 632.746 and any rules promulgated under s. 632.7465. The notice may be sent to the terminated insured's home address as shown on the records of the employer.

SECTION 33. 632.897 (9) (c) of the statutes is amended to read:

632.897 **(9)** (c) When the insurer is notified that the coverage of a spouse may be terminated because of a divorce or annulment, the insurer shall provide the former spouse written notification of the right to obtain individual coverage under sub. (4), the premium amounts required and the manner, place and time in which premiums may be paid. This notice shall be given not less than 30 days before the former spouse's coverage would otherwise terminate. The premium shall be determined in accordance with the insurer's table of premium rates applicable to ~~the age and class of risk of~~ every person to be covered and to the type and amount of coverage provided, subject to s. 632.746 and any rules promulgated under s. 632.7465. If the former spouse tenders the first monthly premium to the insurer within 30 days after the notice provided by this paragraph, sub. (4) shall apply and the former spouse shall receive individual coverage commencing immediately upon termination of his or her coverage under the insured's policy.

SECTION 34. Chapter 635 (title) of the statutes is amended to read:

CHAPTER 635

SMALL EMPLOYER

HEALTH INSURANCE PLAN

SECTION 35. Subchapter I of chapter 635 [precedes 635.01.] of the statutes is repealed.

SECTION 36. 635.20 (intro.) of the statutes is amended to read:

635.20 Definitions. (intro.) In this ~~subchapter~~ chapter:

SECTION 37. Subchapter II (title) of chapter 635 [precedes 635.20] of the statutes is repealed.

SECTION 38. 635.20 (1c) of the statutes is repealed and recreated to read:

635.20 **(1c)** "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.

SECTION 39. 635.20 (1m) of the statutes is repealed and recreated to read:

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

SECTION 40. 635.20 (10) of the statutes is amended to read:

635.20 **(10)** "Plan" means the health insurance plan for individuals employed by small employers that is created under s. 635.21 and that consists of a policy under this ~~subchapter~~ chapter containing the basic benefits.

SECTION 41. 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. "Small employer insurer" 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 42. 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 a policy under this ~~subchapter~~ chapter containing the basic benefits, an employer:

SECTION 43. 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 employer that purchases a policy under this ~~subchapter~~ chapter 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 to the end of the policy period.

SECTION 44. 635.25 (1m) of the statutes is amended to read:

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

SECTION 45. 635.254 (1) of the statutes is amended to read:

635.254 **(1)** An employer that participates in the plan 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.

SECTION 46. 635.254 (3) of the statutes is amended to read:

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

SECTION 47. 635.26 (1s) of the statutes is repealed.

SECTION 48. 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 their duties under this ~~subchapter~~ chapter.

SECTION 49. 635.29 of the statutes is amended to read:

635.29 (title) **Applicability of health insurance mandates.** The health insurance mandates apply to the plan under this ~~subchapter~~ chapter only to the extent determined by the plan board under s. 635.23 (1) (b).

SECTION 50. 635.31 of the statutes is amended to read:

635.31 Chapters 600 to 655 applicable. Except as otherwise provided in this ~~subchapter~~ chapter, the plan shall comply with and be administered in compliance with chs. 600 to 655.

SECTION 51. 646.35 (5) of the statutes is amended to read:

646.35 **(5)** RATE INCREASES. The board may increase any rates or premiums on policies during continuation of coverage under sub. (2) (b) or (3) (b) to the extent the

policies permit the insurer to increase the rates or premiums and subject to s. 632.746 and any rules promulgated under s. 632.7465. If the board determines that the rates or premiums on policies which do not permit an increase or the rates or premiums as increased to the extent permitted by the policies are inadequate under s. 625.11 (3), the board may offer the policyholders the option of terminating the coverage or continuing the coverage at adequate rates or premiums as determined by the board.

SECTION 52. Nonstatutory provisions.

(1) RULES ON RISK ADJUSTMENT MECHANISM. The commissioner of insurance shall submit proposed rules required under section 632.747 (4) (a) of the statutes, as created by this act, to the legislative council staff for review under section 227.15 (1) of the statutes no later than April 1, 1996.

SECTION 53. Initial applicability.

(1) The treatment of sections 15.735 (1), 185.981 (4t), 185.983 (1) (intro.) and (1g), 600.01 (2) (b), 601.424, 625.03 (6), 625.12 (2), 625.15 (1), 625.22 (1) and (4), 628.34 (3) (c), 628.36 (2) (b) 1., 3. and 5., 631.01 (4), 632.70, 632.745, 632.746, 632.7465, 632.747, 632.748, 632.749, 632.76 (2) (a), 632.896 (4), 632.897 (2) (d) and (9) (c), 635.20 (intro.), (1c), (1m), (10) and (13), 635.25 (1) (a) (intro.) and (b), 635.26 (1s), 635.28, 635.29, 635.31 and 646.35 (5), chapter 635 (title) and subchapter I and subchapter II (title) of chapter 635 of the statutes first applies to health benefit plans issued or renewed on October 1, 1996.

SECTION 54. Effective date. This act takes effect on October 1, 1996, except as follows:

(1) The treatment of sections 619.12 (1) (intro.), 632.727, 632.747 (4) and (5) and 632.83 of the statutes and SECTION 52 (1) of this act take effect on the day after publication.

(END)