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Details: Emergency Rules by Office of the Commissioner of Insurance.
(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2009-10
(session year)

Joint
(Assembly, Senate or Joint)

Committee for Review of Administrative Rules ...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (June 2012)

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

Wisconsin.gov

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September 24, 2009

Members of the Legislature

Re: Emergency Rule affecting Section Ins 3.36, Wis. Adm. Code, relating to treatment for autism spectrum disorders and affecting small business

Dear Senator or Representative to the Assembly:

I have promulgated the attached rule as an emergency rule. The rule will be published in the official State newspaper approximately on September 26, 2009.

The attached copy of the rule includes the Finding of Emergency which required promulgation of the rule.

If you have any questions, please contact Julie E. Walsh at (608) 264-8101 or e-mail at julie.walsh@wisconsin.gov.

Sincerely,

Sean Dilweg
Commissioner of Insurance

SD:JW
Attachment: 1 copy rule

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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STATE OF WISCONSIN |
| SS
OFFICE OF THE COMMISSIONER OF INSURANCE |

I, Sean Dilweg, Commissioner of Insurance and custodian of the official records, certify that the annexed emergency rule affecting Section Ins 3.36, Wis. Adm. Code, relating to treatment for autism spectrum disorders and affecting small business, is duly approved and adopted by this Office on September 22, 2009.

I further certify that I have compared this copy with the original on file in this Office and that it is a true copy of the original, and the whole of the original.

IN TESTIMONY WHEREOF, I have hereunto set my hand at 125 South Webster Street, Madison, Wisconsin, on September 22, 2009.

Sean Dilweg
Commissioner of Insurance

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE CREATING A RULE

To create Ins 3.36, Wis. Adm. Code,

Relating to treatment of autism spectrum disorders and affecting small business.

FINDING OF EMERGENCY

The Commissioner of Insurance pursuant to s. 632.895 (12m) (f) 2., Stats., need not find that an emergency exists nor provide evidence that promulgating a rule is necessary for the preservation of the public peace, health, safety or welfare.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. **Statutes interpreted:**

   ss. 600.01, 628.34 (12), 632.895 (12m) Stats.

2. **Statutory authority:**

   ss. 600.01 (2), 601.41 (3), 601.42, 628.34 (12), Stats.

3. **Explanation of OCI's authority to promulgate the proposed rule under these statutes:**

The statutes all relate to the commissioner's authority to promulgate rules regulating the business of insurance as it relates to disability insurance products. Specifically, s. 632.895 (12m) (f), Wis. Stats., requires the commissioner to define "intensive-level services," "nonintensive-level services," "paraprofessional," and "qualified" for purposes of providing services under this subsection. The statute further authorizes that the commissioner may promulgate rules governing the interpretation or administration of this subsection.

4. **Related statutes or rules:**

There are no other statutes or rules that mandate services for autism spectrum disorders. This rule creates a new section to implement the newly created mandate pursuant to 2009 Wis. Act 28.

5. **The plain language analysis and summary of the proposed rule:**

Under 2009 Wisconsin Act 28, the Commissioner is required pursuant to s. 632.895 (12m), Stats., to define four terms: intensive level services, non-intensive level services, qualified, and paraprofessionals; and may draft rules that relate to the interpretation or administration of section.

To ensure clear understanding of current provider qualifications and treatment options for autism spectrum disorders the Commissioner established the Autism Working Group. The work group was charged with advising the Commissioner on definitions for the four required terms and making recommendations on how the statute should be implemented. The group was composed of parents, providers, insurers, and advocates. Administrators of the Waiver program at the Department of Health services also participated. The group met every other week beginning June 23rd, 2009 until September 10th, 2009

The Waiver program was used as a baseline to discuss the implementation of the new mandate. Current literature on autism spectrum disorders and information from other states was presented to the working for review and consideration. Because the research and literature in the realm of autism treatments is rapidly evolving, the working group recommended defining "evidence-based" and "behavioral" rather than creating a list of approved therapies that could readily become outdated.

The proposed rule includes definitions of intensive level behavioral therapy and non-intensive level therapy. Based upon current research, the rule limits intensive level services to children aged 2 to 9 as this period of time has shown to be the optimum time for gains for individuals diagnosed with autism spectrum disorders. Building from the waiver program, the working group developed a comprehensive regulation.

The proposed rule contains criteria necessary for one to be considered qualified provider, qualified professional, qualified therapist and qualified paraprofessional. The criteria include a combination of educational, professional and specific training with individuals

diagnosed with autism spectrum disorders and for qualified paraprofessionals specific requirements for supervised implementation of a treatment plan for the insured. The rule includes provisions to permit individuals who are currently providing services through the department's waiver program to be deemed qualified for up to two years and permit insurers and self-funded plans to contract with these individuals who are experienced but may not met the "qualified" requirements.

The rule also handles several administrative concerns. It allows insurers to deny claims they believe to be fraudulent, exclude travel time from the required hours of treatment and allocated dollars for treatment and permits dispute resolution through independent review organizations.

6. **Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:**

Autism Treatment Acceleration Act of 2009 (S. 819, H.R. 2413) was proposed in May. If passed, Section 12 will require all insurance companies across the country to provide coverage for evidence-based, medically-necessary autism treatments and therapies. If passed a comparison of final federal requirements and state law and regulation will need to be reviewed.

Additionally, the "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008" (29 U.S.C. 1185a), requires for group health plans that offer both medical and surgical benefits and mental health or substance use disorder benefits to ensure financial and treatment limitations are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan. Further the federal law does not permit separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. Federal guidance is due this fall on the Mental Health Equity Act of 2008. Wisconsin's law is broader than the federal act but will need to be reviewed when the federal regulations are finally promulgated and effective.

7. **Comparison of similar rules in adjacent states as found by OCI:**

Illinois: Public Act 95-1005 requires private insurers cover autism benefits for children under 21 years of age. No rule-making accompanied this law, however, the statute does include Applied Behavioral Analysis, intervention, and modification as a part of the covered behavioral treatments. The law is subject to pre-existing condition limitations. It is also subject to denials based on medical necessity.

Iowa: A bill, SF 1 was introduced in the Iowa legislature this year but did not pass. There are no other similar laws or rules in Iowa.

Michigan: Two bills - HB 4183 and 4176 - requiring autism coverage, have passed the Michigan House; however, they are not expected to reach a vote this year. There are no other similar laws or rules in Michigan.

Minnesota: A bill, SF 695 was introduced in the Minnesota legislature this year but did not pass. There are no other similar laws or rules in Minnesota.

8. **A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:**

The Commissioner created an advisory Autism Working Group to assist in the development of workable definitions of "intensive" and "nonintensive" level services; "qualified" providers and "paraprofessionals." The advisory working group was comprised of providers, insurers, advocates, parents of autistic children and representatives from the Department of Health Services familiar with the Medicaid waiver program for autism services. The working group met seven times between June 23 and September 10, 2009. This proposed rule reflects the advisory working group's recommendations.

9. **Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:**

There are no insurers offering disability insurance or state or local governmental self-funded entities that meet the definition of a small business.

10. **See the attached Private Sector Fiscal Analysis.**

See attached.

11. A description of the Effect on Small Business:

This rule will have little or no effect on small businesses

12. Agency contact person:

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at: **http://oci.wi.gov/ocirules.htm**

or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: inger.williams@wisconsin.gov
Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on the 14th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins 336
Office of the Commissioner of Insurance
PO Box 7873
Madison WI 53707-7873

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Web site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

SECTION 1. Ins 3.36 is created to read:

Ins 3.36 **(1) APPLICABILITY.** This section applies to disability insurance policies as defined in s. 632.895 (1) (a), Stats., except as provided in s. 632.895 (12m) (e), Stats., and self-insured health plans sponsored by the state, county, city, town, village, or school district that

provides coverage to dependents issued or renewed on or after November 1, 2009 or the date the policies or plans are established, extended, modified, or renewed on or after November 1, 2009 for collectively bargained agreements containing provisions for health plans or policies.

(3) DEFINITIONS. In addition to the definitions in s. 632.895 (12m) (a), Stats., in this section:

(a) "Behavioral" means interactive therapies that target observable behaviors to build needed skills and to reduce problem behaviors using well-established principles of learning utilized to change socially important behaviors with the goal of building a range of communication, social and learning skills, as well as reducing challenging behaviors.

(b) "Department" means the Wisconsin Department of Health Services.

(c) "Evidence-based" means therapy that is based upon medical and scientific evidence as defined at s. 632.835 (3m) (b) 1., 2., and 2.a., Stats., and s. Ins 18.10 (4), and is determined to be an efficacious treatment or strategy.

(d) "Efficacious treatment" or "efficacious strategy" means treatment or strategies designed to address cognitive, social or behavioral conditions associated with autism spectrum disorders; to sustain and maximize gains made during intensive-level services; or to improve an individual with autism spectrum disorder's condition.

(e) "Intensive-level service" means evidence-based behavioral therapies that are directly based on, and related to, an insured's therapeutic goals and skills as prescribed by a physician familiar with the insured.

(f) "Provider" means a state-licensed psychiatrist, psychologist, or a social worker certified or licensed to practice psychotherapy.

(g) "Qualified paraprofessional" means an individual working under the active supervision of a qualified supervising provider and who complies with all of the following:

1. Attains at least 18 years of age.

2. Obtains a high school diploma

3. Completes a criminal background check.

4. Obtains at least 20 hours of training that includes subjects related to autism, evidence-based treatment methods, communication, teaching techniques, problem behavior issues, ethics, special topics, natural environment, and first aid.

5. Obtains at least 10 hours of training in the use of behavioral evidence-based therapy including the direct application of training techniques with an individual who has autism spectrum disorder present.

6. Receives regular, scheduled oversight by a qualified provider in implementing the treatment plan for the insured.

(h) "Qualified provider" means an individual acting within the scope of a currently valid state-issued license for psychiatry or psychology or a social worker licensed or certified to practice psychotherapy and who has completed at least 2080 hours that includes all of the following:

1. Fifteen hundred hours supervised training involving direct 1:1 work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models.

2. Supervised experience with all of the following:

a. Working with families as the primary provider and ensuring treatment compliance.

b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.

c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.

d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.

e. Designing and implementing progressive treatment programs for individuals with autism spectrum disorders.

3. Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

(i) "Qualified professional" means an individual working under the supervision of an outpatient mental health clinic who is a licensed treatment professional as defined in s. DHS 35.03 (9g), and who has completed at least 2080 hours including all of the following:

1. Fifteen hundred hours supervised training involving direct 1:1 work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models.

2. Supervised experience with all of the following:

a. Working with families as part of a treatment team and ensuring treatment compliance.

b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.

c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.

d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.

3. Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

(j) "Qualified supervising provider" means a qualified provider that is a currently valid state-licensed psychiatrist, psychologist or a social worker licensed or certified as a psychotherapist and the qualified provider has completed at least 4160 hours of experience as a supervisor of less experienced providers, professionals and paraprofessionals.

(k) "Qualified therapist" means a speech-language pathologist or occupational therapist acting within the scope of a currently valid state issued licensed and who has completed at least 1200 hours of training including all of the following:

1. Seven hundred fifty hours supervised training involving direct 1:1 work with individuals, including pediatric individuals, with autism spectrum disorders using evidence-based, efficacious therapy models.

2. Supervised experience with all of the following:

a. Working with families as the direct speech or occupational therapist and ensuring treatment compliance.

b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.

c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.

d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in language ability and adaptive and social interaction skills.

(L) "Therapy" means services, treatments and strategies prescribed by a treating physician and provided by a qualified provider to improve the insured's condition or to achieve social, cognitive, communicative, self-care or behavioral goals that are clearly defined within the insured's treatment plan.

(m) "Therapist" means a state-licensed speech-language pathologist or occupational therapist acting within the scope of a currently valid state license.

(n) "Waiver program" means services provided by the department through the Medicaid Home and Community-Based Services as granted by the Centers for Medicare & Medicaid Services.

3.36 (3) Verified diagnosis. Insurers and self-insured health plans shall provide coverage for services to an insured that who a primary verified diagnosis of autism spectrum disorder when made by a provider skilled in testing and in the use of empirically validated tools specific for autism spectrum disorders.

(a) Insurers and self-insured health plans shall accept as valid and provide coverage of the diagnostic testing in addition to the benefit mandated by s. 632.895 (12m), Stats. For the diagnosis to be valid for autism spectrum disorder, the testing tools shall be appropriate to the presenting characteristics and age of the insured and be empirically validated for autism spectrum disorders to provide evidence that the insured meets the criteria for autism spectrum disorder in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Insurers and self-insured health plans may require confirmation of a primary diagnosis through completion of empirically validated tools or tests from each of the following categories: intelligence, parent report, language skills, adaptive behavior, and direct observation of the child.

(b) An insurer and a self-insured health plan may require an insured to obtain a second opinion from a provider experienced in the use of empirically validated tools specific for autism spectrum disorders that is mutually agreeable to the insured or the insured's parent or authorized representative and to the insurer or self-insured health plan. An insurer and a self-insured health plan shall cover the cost of the second opinion and the cost of the second opinion shall be in addition to the benefit mandated by s. 632.895 (12m), Stats.

(c) Insurers and self-insured health plans may require that the assessment include both a standardized parent interview regarding current concerns and behavioral history as well as

direct, structured observation of social and communicative behavior and play. The diagnostic evaluation should also assess those factors that are not specific to an autism spectrum disorders including degree of language impairment, cognitive functioning, and the presence of nonspecific behavioral disorders.

3.36 (4) Intensive-level Services. (a) Insurers and self-insured health plans shall provide coverage for evidence-based behavioral intensive-level therapy for an insured with a verified diagnosis of autism spectrum disorder, the majority of which shall be provided to the insured when the parent or legal guardian is present and engaged and all of the prescribed therapy is consistent with all of the following requirements:

1. Based upon a treatment plan developed by a qualified provider that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment, and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the insured be present and engaged in the intervention.

2. Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals.

3. Provided in an environment most conducive to achieving the goals of the insured's treatment plan.

4. Included training and consultation, participation in team meetings and active involvement of the insured's family and treatment team for implementation of the therapeutic goals developed by the team.

5. Commenced after an insured is two years of age and before the insured is nine years of age.

6. The insured is directly observed by the qualified provider at least once every two months.

(b) Four cumulative years. Insurers and self-insured health plans shall provide up to four years of intensive-level services. Insurers and self-insured health plans may credit against the required four years of intensive-level services any previous intensive-level services the insured received regardless of payor. Insurers and self-insured health plans may require documentation including medical records and treatment plans to verify any evidenced-based behavioral therapy the insured received for autism spectrum disorders that was provided to the insured prior to the insured attaining nine years of age. Insurers and self-insured health plans may consider any evidence-based behavioral therapy that was provided to the insured for an average of 20 or more hours per week over a continuous six-month period to be intensive-level services.

(c) Travel. Insurers and self-insured health plans shall not include coverage of travel time for qualified providers, supervising providers, professionals, therapists or paraprofessionals when calculating the number of hours of care provided per week and are not required to separately reimburse for travel time.

(d) Progress assessment. Insurers and self-insured health plans shall require that progress be assessed and documented throughout the course of treatment. Insurers and self-insured health plans may request and review the insured's treatment plan and the summary of progress on a periodic basis.

3.36 (5) Nonintensive-Level Services. (a) Insurers and self-insured health plans must provide coverage for an insured with a verified diagnosis of autism spectrum disorder for nonintensive-level services that are evidence-based and that are provided to an insured by a qualified provider, professional, therapist or paraprofessional in either of following conditions:

1. After the completion of intensive-level services and designed to sustain and maximize gains made during intensive-level services treatment.

2. To an insured who has not and will not receive intensive-level services but for whom nonintensive-level services will improve the insured's condition.

(b) Insurers and self-insured health plans shall provide coverage for evidence-based therapy that is consistent with all of the following requirements:

1. Based upon a treatment plan developed by a qualified provider, supervising provider, professional or therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the insured be present and engaged in the intervention.

2. Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals

3. Provided in an environment most conducive to achieving the goals of the insured's treatment plan.

4. Included training and consultation, participation in team meetings and active involvement of the insured's family in order to implement the therapeutic goals developed by the team.

5. Provided supervision of providers, professionals, therapists and paraprofessionals by qualified supervising providers on the treatment team.

(c) Services. Insurers and self-insured health plans shall provide coverage for nonintensive-level services that may include direct or consultative services when provided by qualified providers, qualified supervising providers, qualified professionals, qualified paraprofessionals, or qualified therapists.

(d) Progress assessment. Insurers and self-insured health plans shall require that progress be assessed and documented throughout the course of treatment. Insurers and self-insured health plans may request and review the insured's treatment plan and the summary of progress on a periodic basis.

(e) Travel. Insurers and self-insured health plans shall not include coverage of travel time by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals when calculating the number of hours of care provided per week and are not required to separately reimburse for travel time.

3.36 (5) Transition to nonintensive-level services. (a) Insurers and self-insured plans shall provide notice to the insured or the insured's authorized representative regarding change in an insured's level of treatment. The notice shall indicate the reason for transition that may include any of the following:

1. The insured has received four cumulative years of intensive-level services.

2. The insured no longer requires intensive-level services as supported by documentation from a qualified provider or supervising provider.

3. The insured no longer receives evidence-based behavioral therapy for at least 20 hours over a six-month period of time.

(b) Insurers and self-insured plans may require an insured or an insured's authorized representative to timely notify the insurer or self-insured plan if the insured requires and qualifies for intensive-level services but the insured or the insured's family or care giver is unable to receive intensive-level services for an extended period of time. The insured or the insured's authorized representative shall indicate the specific reason or reasons the insured or the insured's family or care giver are unable to comply with an intensive-level service treatment plan. Reasons for requesting intensive-level services be interrupted for an extended period of

time may include a significant medical condition, surgical intervention and recovery, catastrophic event or any other reason the insurer or self-insured plan determines to be acceptable.

(c) Insurers and self-insured plans may not deny intensive-level services to an insured for failing to maintain at least 20 hours per week of evidence-based behavioral therapy over a six-month period when the insured or the insured's authorized representative complied with par. (b) or the insured or the insured's authorized representative can document that the insured failed to maintain at least 20 hours per week of evidence-based behavioral therapy due to waiting for waiver program services.

3.36 (6) Notice to Insureds. Insurers and self-insured plans shall provide written notice regarding claims submitted and processed for the treatment of autism spectrum disorders to the insured or insured's parents or authorized representative and include the total amount expended to date for the current policy year. The notice may be included with the explanation of benefits form or in a separate communication provided on a periodic basis during the course of treatment.

3.36 (7) Research that is the basis for efficacious treatment or efficacious strategies.

(a) Research designs that are sufficient to demonstrate that a treatment or strategy when used solely or in combination with other treatments or strategies, is effective in addressing the cognitive, social, and behavioral challenges associated with autism spectrum disorders demonstrates significant improvement must include at least one of the following:

1. Two or more high quality experimental or quasi-experimental group design studies that meet all of the following criteria:

a. A clearly defined population for whom inclusion criteria have been delineated in a reliable, valid manner.

b. Outcome measures with established reliability and construct validity.

c. Independent evaluators who are not aware of the particular treatment utilized.

2. Five or more single subject design studies that meet all of the following criteria:

a. Studies must have been published in a peer-reviewed scientific or medical journal.

b. Studies must have been conducted by three different researchers or research groups in three different geographical locations.

c. The body of studies must have included 20 or more participants.

3. One high quality randomized or quasi-experimental group design study that meets all of the criteria in subpar. 1 and three high quality single subject design studies that meet all of the criteria in subpar. 2.

3.36 (9) Disputes. (a) An insurer's or a self-insured health plan's determination regarding diagnosis and level of service may be considered an adverse determination if the insured disagrees with the determination. The insured or the insured's authorized representative may file a grievance in accordance with s. Ins 18.03. The insured or the insured's authorized representative may seek independent review of the adverse determination in accordance with s. Ins 18.11.

3.36 (10) Non-required coverage. (a) Services. Insurers and self-insured health plans are not required to cover any of the following:

1. Acupuncture.

2. Animal-based therapy including hippotherapy.

3. *Auditory integration training.*

4. Chelation therapy.

5. Child care fees.

6. Cranial sacral therapy.

7. Custodial or respite care.

8. Hyperbaric oxygen therapy.

9. Special diets or supplements.

(b) Drug and devices. Insurers and self-insured health plans shall not provide coverage for pharmaceuticals or durable medical equipment through s. 632.895 (12m), Stat. Coverage of pharmaceuticals and durable medical equipment shall be covered in compliance with the terms of the insured's policy.

(c) Fraudulent claims. Insurers and self-insured health plans shall not be required to pay claims that have been determined to be fraudulent.

(d) Parents of children diagnosed with autism spectrum disorders. Insurers and self-insured health plans shall not be required to pay for treatment rendered by parents or legal guardians who are otherwise qualified providers, supervising providers, therapists, professionals or paraprofessional for treatment rendered to their own children.

3.36 (11) Locations for Services. (a) Insurers and self-insured health plans shall cover treatments, therapies and services to an insured diagnosed with autism spectrum disorders in locations including the provider's office or clinic, or in a setting conducive to the acquisition of the target skill. Treatments may be provided in schools when they are related to the goals of the treatment plan and do not duplicate services provided by a school.

(b) Insurers and self-insured health plans are not required to cover therapy, treatment or services when provided to an insured who is residing in a residential treatment center, inpatient treatment or day treatment facility.

(c) Insurers and self-insured health plans are not required to cover the cost for the facility or location or for the use of a facility or location when treatment, therapy or services are provided outside an insured's home.

3.36 (12) Annual publication CPI adjustment. The commissioner shall publish to the office of the commissioner of insurance website on or before December 1 of each year beginning December 1, 2011, the consumer price index for urban consumers as determined by the U.S. Department of Labor and publish the adjusted dollar amount in accordance with s. 632.895 (12m) (c) 1., Stats. The adjusted dollar amount published each December shall be used by insurers and self-insured health plans when complying with s. 632.895 (12m), Stats., effective the following January 1 for newly issued policies or on the first date of a modified, extended or renewed policy or certificate after January 1.

3.36 (14) Verification of qualified provider, supervising provider, therapist, professional and paraprofessional. (a) Insurers and self-insured health plans are required to verify the licensure, certification and all training or other credentials of a qualified provider, qualified supervising provider and qualified therapist.

(b) Insurers and self-insured health plans shall require the qualified provider or certified outpatient mental health clinics employing or contracting for the services of qualified professionals or qualified paraprofessionals to verify the qualified professional's or qualified paraprofessional's credentials and to document that the qualified professional or qualified paraprofessional has not been convicted of a felony or any crime involving maltreatment of a child in any jurisdiction. Insurers and self-insured health plans may receive documentation from the qualified providers or certified outpatient mental health clinics upon request and may require periodic review and verification.

(c) A provider, therapist, paraprofessional or professional working under the supervision of a certified outpatient mental health clinic that is approved by the Department and has a signed Medicaid provider agreement to provide services through the waiver program to individuals with autism spectrum disorders prior to November 1, 2009 shall be deemed to be a qualified provider, therapist or professional through October 31, 2011. Beginning November 1, 2011 any provider, supervising provider, therapist, paraprofessional or professional must

comply with the applicable requirements to be considered a qualified provider, supervising provider, therapist or professional.

(d) An insurer or self-insured health plans may elect to contract with certain providers, therapists, paraprofessionals and professionals that do not meet all of the requirements necessary to be considered qualified providers, therapists, paraprofessionals or professionals, but are approved by the Department and have a signed Medicaid provider agreement to provide services through the waiver program to individuals with autism spectrum disorders and meet any criteria established y the insurer or self-insured health plan. The insurer and self-insured health plans must have a verifiable and established process for rendering its determination for otherwise qualified providers, therapists and professionals.

SECTION 2. These changes first apply to policies issued or renewed on or after November 1, 2009.

SECTION 3. This section may be enforced under ss. 601.41, 601.64, 601.65, 628.10, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

SECTION 4. These emergency rule changes will take effect as provided in s. 227.24(1)(c), Stats.

Dated at Madison, Wisconsin, this 18 day of September, 2009.

Sean Dilweg
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

for Section Ins 3.36 relating to autism spectrum disorders treatment and affecting small business

This rule change will have no significant effect on the private sector regulated by OCI.

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

Wisconsin Department of Administration

FISCAL ESTIMATE

☒ ORIGINAL ☐ UPDATED

☐ CORRECTED ☐ SUPPLEMENTAL

LRB Number	Amendment No. if Applicable
Bill Number	Administrative Rule Number **INS 336**

Subject
autism spectrum disorders treatment and affecting small business

Fiscal Effect

State: ☒ No State Fiscal Effect

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

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

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

☐ Decrease Costs

Local: ☒ No local government costs

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

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

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

Long-Range Fiscal Implications

None

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

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

Wisconsin Department of Administration

FISCAL ESTIMATE WORKSHEET

Detailed Estimate of Annual Fiscal Effect

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 336**

Subject
autism spectrum disorders treatment and affecting small business

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

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

NET ANNUALIZED FISCAL IMPACT

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

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


FORWARD
E PLURIBUS UNUM

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, *Governor*
Sean Dilweg, *Commissioner*

Wisconsin.gov

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September 28, 2009

THE HONORABLE JIM HOLPERIN
SENATE CO-CHAIRPERSON
JOINT COMM FOR REVIEW OF ADM RULES
SOUTH STATE CAPITOL RM 409
MADISON WI 53702

Re: Emergency Rule affecting Section Ins 3.75, Wis. Adm. Code, relating to continuation of group health insurance policies and affecting small business

Dear Senator Holperin:

I will be promulgating an emergency rule. Attached is a draft of the rule for your review. The reasons for proceeding with an emergency rule are given in the Finding of Emergency in the rule. It will be published in the official State newspaper in about a week.

If you have any questions, please contact Robert Luck at (608) 266-0082 or e-mail at robert.luck@wisconsin.gov.

Sincerely,

Sean Dilweg
Commissioner of Insurance

SD:RL
Attachment: 1 copy draft rule

EMERGENCY ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

CREATING A RULE

To create Ins 3.75, Wis. Adm. Code,

Relating to continuation of group health insurance policies.

FINDING OF EMERGENCY

Under 2009 Act 11, s. 9126, a Finding of Emergency is not required for this emergency rule. The relevant portion of 2009 Act 11 reads as follows:

2009 Wisconsin Act 11, SECTION 9126. Nonstatutory provisions; Insurance.

(4) CONTINUATION COVERAGE RULES (a) Notwithstanding section 632.897 of the statutes and subsections (1), (2), and (3), the commissioner of insurance may promulgate rules establishing standards requiring insurers to provide continuation of coverage for any individual covered at any time under a group policy who is a state eligible individual to whom subsection (2) or (3) applies or an assistance eligible individual, as defined under section 3001 (a) (3) of the federal act, including rules governing election or extension of election periods, notice, rates, premiums, premium payment, application of preexisting condition exclusions, and election of alternative coverage.

(b) The commissioner may promulgate the rules under paragraph (a) as emergency rules under section 227.24 of the statutes. Notwithstanding section 227.24 (1) (c) of the statutes, emergency rules promulgated under this paragraph may remain in effect for one year and may be extended under section 227.24 (2) of the statutes Notwithstanding section 227.24 (1) (a) and (3) of the statutes, **the commissioner is not required to provide evidence that promulgating a rule under this paragraph as an emergency rule is necessary for the preservation of public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this paragraph**. [Emphasis Added]

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. **Statutes interpreted:**

   ss. 600.01, 628.34 (12), Stats.

2. **Statutory authority:**

   ss. 601.41 (3), 601.42, 632.897, Stats., s. 9126 of 2009 Wisconsin Act 11 and the American Recovery and Reinvestment Act of 2009, P.L. 111-5

3. **Explanation of OCI's authority to promulgate the proposed rule under these statutes:**

   2009 Act 11 specifically permits the commissioner to enact this rule.

4. **Related statutes or rules:**

   ss. 632.746 & 632.897, Stats.

5. **The plain language analysis and summary of the proposed rule:**

The United States Department of the Treasury, Internal Revenue Service published an interpretation of the American Recovery and Reinvestment Act of 2009 that provided a continuation election opportunity for covered employees including former employees when an employer discontinues a group health plan. The proposed rule will consider continuation coverage election options for employees that meet the requirements of s. 632.897, Stat., or s. 9126 of 2009 Wisconsin Act 11 whose employer or former employer discontinues the group health insurance policy. The proposed rule will consider election and eligibility criteria for continuation of coverage through a group policy.

6. **Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:**

The United States Department of the Treasury, Internal Revenue Service published in a frequently asked question and answer format the question of continuation rights for employees and their dependents when employers discontinue a group policy and determined that eligible employees would be able to elect continuation coverage that may be eligible for premium subsidy under the American Recovery and Reinvestment Act of 2009. There is no current state rule or policy on this specific issue.

7. **Comparison of similar rules in adjacent states as found by OCI:**

Illinois: None

Iowa: None

Michigan: None

Minnesota: None

8. **A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:**

This proposed rule would enact for Wisconsin insureds the ability to elect continuation of coverage when an employer discontinues group health insurance consistent with the Internal Revenue Service's interpretation of the American Recovery and Reinvestment Act of 2009.

9. **Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:**

The rule imposes no substantial requirements on small employers but would allow discontinued employees of small employer who have group insurance the ability to elect continuation of health insurance coverage.

10. **See the attached Private Sector Fiscal Analysis.**

11. **A description of the Effect on Small Business:**

This rule will have little or no negative effect on small businesses.

12. **Agency contact person:**

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at:
http://oci.wi.gov/ocirules.htm

or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: inger.williams@wisconsin.gov
Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on the 14th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

Robert Luck
Legal Unit - OCI Rule Comment for Rule Ins 375
Office of the Commissioner of Insurance
PO Box 7873
Madison WI 53707-7873

Street address:

Robert Luck
Legal Unit - OCI Rule Comment for Rule Ins 375
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125 South Webster St – 2nd Floor
Madison WI 53703-3474

Email address:

Robert Luck
robert.luck@wisconsin.gov

Web site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

SECTION 1. Ins 3.75 is created to read:

Ins 3.75 Continuation of Discontinued Employer Provided Health Group Policy Coverage For Employees and their Dependents.

(1) PURPOSE. The purpose of this rule is to allow assistance eligible individuals to elect continued coverage provided under s. 632.897, Stats., in circumstances where the group policy is otherwise discontinued on or after June 30, 2009 and not replaced. The rule applies only to individuals who are eligible for a premium subsidy under the federal American Recovery and Reinvestment Act of 2009. The federal act makes the premium subsidy available to those individuals who are eligible due to an involuntary employment termination prior to January 1, 2010.

(2) DEFINITIONS. In this section, unless the context requires otherwise:

(a) "Assistance eligible individual" has the meaning provided in Section 3001 (a) (3) of the federal act.

(b) "Terminated insured" means a terminated insured under s. 632.897 (1) (f) and (2) (b) 2, Stats., whose employment has been involuntarily terminated, who has been continuously covered under a group policy for at least 3 months and who:

1. Would be entitled to elect continued coverage under s. 632.897, Stats., but for the fact that the group policy was discontinued on or after June 30, 2009 and not replaced by another group policy offered by the employer during the terminated insured's 30 day election period under s. 632.897 (3) (a), Stats.; or

2. Is receiving, on behalf of themselves and, if applicable, a spouse or dependents, continued coverage under s. 632.897, Stats., due to an involuntary termination of employment that occurred on or after September 1, 2008 and, on or after June 30, 2009, the group policy is discontinued and not replaced by a group policy offered by the employer.

(c) "Federal act" means the American Recovery and Reinvestment Act of 2009, P.L. 111-5.

(3) ADDITIONAL CONTINUATION COVERAGE ELECTION OPPORTUNITY FOR ASSISTANCE ELIGIBLE INDIVIDUALS WHEN AN EMPLOYER DISCONTINUES AND DOES NOT REPLACE GROUP POLICY COVERAGE.

(a) Except as provided in pars. (c) and (d) an insurer shall permit a terminated insured to elect continuation of coverage under the terms of an employer's group policy if:

1. The group policy is discontinued on or after the effective date of this rule and not replaced.

2. The group policy was discontinued on or after June 30, 2009 and prior to the effective date of this rule and not replaced.

(b) An insurer shall permit a terminated insured to elect continuation of coverage on behalf of themselves and the terminated insured's spouse and dependents if the spouse or dependents are covered under the group policy at the time the group policy was discontinued.

(c) An insurer may limit continuation of coverage under this section to individuals who are eligible for premium assistance under the federal act and who are assistance eligible individuals.

(d) This section does not require continuation of coverage if the individual:

1. Establishes residence outside this state.
2. Fails to make timely payment of a required premium amount after notice as required under s. 631.36, Stats.
3. Becomes eligible for similar coverage under another employer's group policy or for benefits under title XVIII of the Social Security Act.
4. Ceases to be eligible for premium assistance under s. 3001 (a) (2) of the federal act.
5. The individual's eligibility for continued coverage would have otherwise ceased under s. 632.897, Stats., if the group policy had not been discontinued.

(e) Coverage under this section, if elected under par. (a), shall continue uninterrupted from the date of the employer's discontinuance of the group policy . An insurer is not required to continue coverage for a period covered by a conversion policy issued under s. 632.897, Stats., for the period prior to the date of election of continuation coverage.

(f) An insurer shall provide a right to an individual conversion policy on termination of continuation of coverage under this section if the terminated insured tenders the first premium within 30 days after the continued coverage terminates. The insurer shall either include notice of this right and a description of how to make payment of premium in the notice required under sub. (4) or shall provide notice prior to termination of the continuation coverage. The conversion policy shall conform to the requirements of s. 632.897 (4), Stats. An insurer is not required to issue a conversion policy under this paragraph if issuance of an individual conversion policy is not required under the standards established in s. 632.897 (4) (d), Stats.

(4) NOTICE. (a) An employer shall provide written notice in the form required by par. (b) to each terminated insured prior to the date of discontinuance of the group policy except the employer shall provide the notice within 30 days of the effective date of this rule for an employer group policy discontinued on or after June 30, 2009 and

prior to the effective date of this rule. An employer or insurer is not required to give notice to a terminated insured who is not, and who is not entitled to elect coverage for, an assistance eligible individual.

(b) The notice required under this subsection shall include a description of the discontinuance of the group policy, the right to continuation under sub. (3) (a) and (b), an explanation of the procedure for electing continued coverage including par. (d), the payment amounts required for continuation coverage, and the manner, place, and time in which the payments shall be paid. The notice shall also include a description of the premium subsidy, the notice required under section 3001 (a) (7) of the federal act and a description of when the continuation coverage will discontinue, including a description of discontinuance under subd. (3) (d) 4.

(c) If an employer that is required to provide the notice as required under par. (a) and (b) fails to provide the notice within the time required, the insurer shall provide the notice specified in par. (b) within 10 days after the date the insurer acquires knowledge the employer has not provided the notice or the date the insurer exercising due diligence should know that the employer has not provided the notice.

(d) Insurance intermediaries shall provide reasonable assistance to insurers by notifying employers of the requirement to provide notice under this subsection and by making reasonable efforts to assist insurers in determining whether the employer complies and, if not, by making reasonable efforts to assist the insurer in giving notice.

(e) A terminated insured may elect continuation of coverage by electing continuation coverage and paying the premium due under sub. (5) (a) to either the employer or the insurer, as directed by the notice required under par. (b), within 30 days after notice is given as required under par. (a) or (c).

(5) PREMIUM. (a) The insurer may charge for coverage continued under this section an amount no more than 100% of the cost the employer incurred for providing the group policy coverage, including group rate adjustments on the date the group policy would have renewed that are based on applying rating factors to group changes that occurred prior to the discontinuance of the group policy. The employer or insurer shall collect only 35% of that amount from the terminated insured. The insurer may collect any premium subsidy available under the federal act.

(b) An insurer may require payment of premium for all required continuation coverage periods, including for periods prior to the date of election or the effective date of this rule.

(c) An employer, if requested by the insurer, shall collect and remit to the insurer premium due under this rule. An insurer may require the employer to collect and remit premium due from a terminated insured, spouse or dependent under this rule. An insurer may not condition continuation of coverage on the employer collection and remittance of premium. An insurer shall treat payment by a terminated insured, spouse or dependent to the employer as receipt and payment to the insurer unless the insurer directs that payment be made to the insurer. An insurer may direct a terminated insured, spouse or dependent to pay the premium to either the employer or to the insurer, including by direction in the notice under sub. (4) (b).

(d) An employer shall notify an insurer when the employer discontinues a group policy and does not replace the group policy. An insurer may require the employer to give it notice when it discontinues a group policy and does not replace the group policy. An insurer may not condition continuation of coverage under this rule on employer notice of such discontinuance.

(6) PORTABILITY; HIRSP. For an individual who elects continuation of coverage under

this section, the period, if any, from the date of the termination of the individual's group policy coverage to the commencement of continuation of coverage under this section shall be disregarded for the purpose of determining the 63-day period under section 632.746 (3) (b), Stats., and determining eligibility as an eligible individual under ch. 149, Stats.

(7) CONTRACT TERMS PRESERVED. An insurer may restrict coverage provided under this section to the terms of the group policy to the extent the terms do not conflict with this rule. Nothing in this section prohibits an insurer from applying deductibles and other cost sharing according to the terms of the group policy, including according to policy periods based on renewal dates that would have occurred had the policy not been discontinued. An insurer may apply policy modifications that were included in notice given to the employer under s. 631.36, Stats., or requested by the employer, that took effect or would have taken effect prior to or on the date of the discontinuance of the policy. An insurer may include provisions for administration of this rule in its group policy and certificates.

SECTION 2. This section may be enforced under ss. 601.41, 601.64, 601.65, 628.10, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

SECTION 3. These emergency rule changes will take effect on the day after publication, as provided in s. 227.24(1)(c), Stats.

Dated at Madison, Wisconsin, this 28th day of September, 2009.

Sean Dilweg
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

for Section Ins 3.75 relating to continuation of group insurance policies and affecting small business

This rule change will have no significant negative effect on the private sector regulated by OCI but will allow numerous people to continue group health insurance that would not be able to without this change.

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

Wisconsin Department of Administration

FISCAL ESTIMATE WORKSHEET

Detailed Estimate of Annual Fiscal Effect

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 3.75**

Subject
continuation of group insurance policies and affecting small business

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

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

NET ANNUALIZED FISCAL IMPACT

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

Prepared by:	Telephone No.	Agency
Robert Luck	(608) 266-0082	Insurance
Authorized Signature:	**Telephone No.** (608) 267-3782	**Date** (mm/dd/ccyy) 09/28/2009

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

Wisconsin Department of Administration

FISCAL ESTIMATE

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 3.75**

Subject

continuation of group insurance policies and affecting small business

Fiscal Effect

State: ☒ No State Fiscal Effect

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

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

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

☐ Decrease Costs

Local: ☒ No local government costs

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

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

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

Long-Range Fiscal Implications

None

Prepared by:	Telephone No.	Agency
Robert Luck	(608) 266-0082	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)
	(608) 267-3782	09/28/2009


FORWARD
E PLURIBUS UNUM

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

Wisconsin.gov

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Madison, Wisconsin 53707-7873
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E-Mail: ociinformation@wisconsin.gov
Web Address: oci.wi.gov

October 1, 2009

Members of the Legislature

Re: Emergency Rule affecting Section Ins 3.75, Wis. Adm. Code, relating to continuation of group health insurance policies and affecting small business

Dear Senator or Representative to the Assembly:

I have promulgated the attached rule as an emergency rule. The rule will be published in the official State newspaper on October 1, 2009.

The attached copy of the rule includes the Finding of Emergency which required promulgation of the rule.

If you have any questions, please contact Robert Luck at (608) 266-0082 or e-mail at robert.luck@wisconsin.gov.

Sincerely,

Sean Dilweg
Commissioner of Insurance

SD:RL
Attachment: 1 copy rule

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

Wisconsin.gov

125 South Webster Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
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E-Mail: ociinformation@wisconsin.gov
Web Address: oci.wi.gov

STATE OF WISCONSIN |
| SS
OFFICE OF THE COMMISSIONER OF INSURANCE |

I, Sean Dilweg, Commissioner of Insurance and custodian of the official records, certify that the annexed emergency rule affecting Section Ins 3.75, Wis. Adm. Code, relating to continuation of group health insurance policies and affecting small business, is duly approved and adopted by this Office on September 28, 2009.

I further certify that I have compared this copy with the original on file in this Office and that it is a true copy of the original, and the whole of the original.

IN TESTIMONY WHEREOF, I have hereunto set my hand at 125 South Webster Street, Madison, Wisconsin, on September 28, 2009.

Sean Dilweg
Commissioner of Insurance

EMERGENCY ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

CREATING A RULE

To create Ins 3.75, Wis. Adm. Code,

Relating to continuation of group health insurance policies.

FINDING OF EMERGENCY

Under 2009 Act 11, s. 9126, a Finding of Emergency is not required for this emergency rule. The relevant portion of 2009 Act 11 reads as follows:

2009 Wisconsin Act 11, SECTION 9126. Nonstatutory provisions; Insurance.

(4) CONTINUATION COVERAGE RULES (a) Notwithstanding section 632.897 of the statutes and subsections (1), (2), and (3), the commissioner of insurance may promulgate rules establishing standards requiring insurers to provide continuation of coverage for any individual covered at any time under a group policy who is a state eligible individual to whom subsection (2) or (3) applies or an assistance eligible individual, as defined under section 3001 (a) (3) of the federal act, including rules governing election or extension of election periods, notice, rates, premiums, premium payment, application of preexisting condition exclusions, and election of alternative coverage.

(b) The commissioner may promulgate the rules under paragraph (a) as emergency rules under section 227.24 of the statutes. Notwithstanding section 227.24 (1) (c) of the statutes, emergency rules promulgated under this paragraph may remain in effect for one year and may be extended under section 227.24 (2) of the statutes Notwithstanding section 227.24 (1) (a) and (3) of the statutes, **the commissioner is not required to provide evidence that promulgating a rule under this paragraph as an emergency rule is necessary for the preservation of public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this paragraph.** [Emphasis Added]

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. **Statutes interpreted:**

   ss. 600.01, 628.34 (12), Stats.

2. **Statutory authority:**

   ss. 601.41 (3), 601.42, 632.897, Stats., s. 9126 of 2009 Wisconsin Act 11 and the American Recovery and Reinvestment Act of 2009, P.L. 111-5

3. **Explanation of OCI's authority to promulgate the proposed rule under these statutes:**

   2009 Act 11 specifically permits the commissioner to enact this rule.

4. **Related statutes or rules:**

   ss. 632.746 & 632.897, Stats.

5. **The plain language analysis and summary of the proposed rule:**

The United States Department of the Treasury, Internal Revenue Service published an interpretation of the American Recovery and Reinvestment Act of 2009 that provided a continuation election opportunity for covered employees including former employees when an employer discontinues a group health plan. The proposed rule will consider continuation coverage election options for employees that meet the requirements of s. 632.897, Stat., or s. 9126 of 2009 Wisconsin Act 11 whose employer or former employer discontinues the group health insurance policy. The proposed rule will consider election and eligibility criteria for continuation of coverage through a group policy.

6. **Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:**

The United States Department of the Treasury, Internal Revenue Service published in a frequently asked question and answer format the question of continuation rights for employees and their dependents when employers discontinue a group policy and determined that eligible employees would be able to elect continuation coverage that may be eligible for premium subsidy under the American Recovery and Reinvestment Act of 2009. There is no current state rule or policy on this specific issue.

7. **Comparison of similar rules in adjacent states as found by OCI:**

Illinois: None

Iowa: None

Michigan: None

Minnesota: None

8. **A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:**

This proposed rule would enact for Wisconsin insureds the ability to elect continuation of coverage when an employer discontinues group health insurance consistent with the Internal Revenue Service's interpretation of the American Recovery and Reinvestment Act of 2009.

9. **Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:**

The rule imposes no substantial requirements on small employers but would allow discontinued employees of small employer who have group insurance the ability to elect continuation of health insurance coverage.

10. **See the attached Private Sector Fiscal Analysis.**

11. **A description of the Effect on Small Business:**

This rule will have little or no negative effect on small businesses.

12. **Agency contact person:**

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at:
http://oci.wi.gov/ocirules.htm

or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: inger.williams@wisconsin.gov
Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on the 14th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

Robert Luck
Legal Unit - OCI Rule Comment for Rule Ins 375
Office of the Commissioner of Insurance
PO Box 7873
Madison WI 53707-7873

Street address:

Robert Luck
Legal Unit - OCI Rule Comment for Rule Ins 375
Office of the Commissioner of Insurance
125 South Webster St – 2nd Floor
Madison WI 53703-3474

Email address:

Robert Luck
robert.luck@wisconsin.gov

Web site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

SECTION 1. Ins 3.75 is created to read:

Ins 3.75 Continuation of Discontinued Employer Provided Health Group Policy Coverage For Employees and their Dependents.

(1) PURPOSE. The purpose of this rule is to allow assistance eligible individuals to elect continued coverage provided under s. 632.897, Stats., in circumstances where the group policy is otherwise discontinued on or after June 30, 2009 and not replaced. The rule applies only to individuals who are eligible for a premium subsidy under the federal American Recovery and Reinvestment Act of 2009. The federal act makes the premium subsidy available to those individuals who are eligible due to an involuntary employment termination prior to January 1, 2010.

(2) DEFINITIONS. In this section, unless the context requires otherwise:

(a) "Assistance eligible individual" has the meaning provided in Section 3001 (a) (3) of the federal act.

(b) "Terminated insured" means a terminated insured under s. 632.897 (1) (f) and (2) (b) 2, Stats., whose employment has been involuntarily terminated, who has been continuously covered under a group policy for at least 3 months and who:

1. Would be entitled to elect continued coverage under s. 632.897, Stats., but for the fact that the group policy was discontinued on or after June 30, 2009 and not replaced by another group policy offered by the employer during the terminated insured's 30 day election period under s. 632.897 (3) (a), Stats.; or

2. Is receiving, on behalf of themselves and, if applicable, a spouse or dependents, continued coverage under s. 632.897, Stats., due to an involuntary termination of employment that occurred on or after September 1, 2008 and, on or after June 30, 2009, the group policy is discontinued and not replaced by a group policy offered by the employer.

(c) "Federal act" means the American Recovery and Reinvestment Act of 2009, P.L. 111-5.

(3) ADDITIONAL CONTINUATION COVERAGE ELECTION OPPORTUNITY FOR ASSISTANCE ELIGIBLE INDIVIDUALS WHEN AN EMPLOYER DISCONTINUES AND DOES NOT REPLACE GROUP POLICY COVERAGE.

(a) Except as provided in pars. (c) and (d) an insurer shall permit a terminated insured to elect continuation of coverage under the terms of an employer's group policy if:

1. The group policy is discontinued on or after the effective date of this rule and not replaced.

2. The group policy was discontinued on or after June 30, 2009 and prior to the effective date of this rule and not replaced.

(b) An insurer shall permit a terminated insured to elect continuation of coverage on behalf of themselves and the terminated insured's spouse and dependents if the spouse or dependents are covered under the group policy at the time the group policy was discontinued.

(c) An insurer may limit continuation of coverage under this section to individuals who are eligible for premium assistance under the federal act and who are assistance eligible individuals.

(d) This section does not require continuation of coverage if the individual:

1. Establishes residence outside this state.
2. Fails to make timely payment of a required premium amount after notice as required under s. 631.36, Stats.
3. Becomes eligible for similar coverage under another employer's group policy or for benefits under title XVIII of the Social Security Act.
4. Ceases to be eligible for premium assistance under s. 3001 (a) (2) of the federal act.
5. The individual's eligibility for continued coverage would have otherwise ceased under s. 632.897, Stats., if the group policy had not been discontinued.

(e) Coverage under this section, if elected under par. (a), shall continue uninterrupted from the date of the employer's discontinuance of the group policy . An insurer is not required to continue coverage for a period covered by a conversion policy issued under s. 632.897, Stats., for the period prior to the date of election of continuation coverage.

(f) An insurer shall provide a right to an individual conversion policy on termination of continuation of coverage under this section if the terminated insured tenders the first premium within 30 days after the continued coverage terminates. The insurer shall either include notice of this right and a description of how to make payment of premium in the notice required under sub. (4) or shall provide notice prior to termination of the continuation coverage. The conversion policy shall conform to the requirements of s. 632.897 (4), Stats. An insurer is not required to issue a conversion policy under this paragraph if issuance of an individual conversion policy is not required under the standards established in s. 632.897 (4) (d), Stats.

(4) NOTICE. (a) An employer shall provide written notice in the form required by par. (b) to each terminated insured prior to the date of discontinuance of the group policy except the employer shall provide the notice within 30 days of the effective date of this rule for an employer group policy discontinued on or after June 30, 2009 and

prior to the effective date of this rule. An employer or insurer is not required to give notice to a terminated insured who is not, and who is not entitled to elect coverage for, an assistance eligible individual.

(b) The notice required under this subsection shall include a description of the discontinuance of the group policy, the right to continuation under sub. (3) (a) and (b), an explanation of the procedure for electing continued coverage including par. (d), the payment amounts required for continuation coverage, and the manner, place, and time in which the payments shall be paid. The notice shall also include a description of the premium subsidy, the notice required under section 3001 (a) (7) of the federal act and a description of when the continuation coverage will discontinue, including a description of discontinuance under subd. (3) (d) 4.

(c) If an employer that is required to provide the notice as required under par. (a) and (b) fails to provide the notice within the time required, the insurer shall provide the notice specified in par. (b) within 10 days after the date the insurer acquires knowledge the employer has not provided the notice or the date the insurer exercising due diligence should know that the employer has not provided the notice.

(d) Insurance intermediaries shall provide reasonable assistance to insurers by notifying employers of the requirement to provide notice under this subsection and by making reasonable efforts to assist insurers in determining whether the employer complies and, if not, by making reasonable efforts to assist the insurer in giving notice.

(e) A terminated insured may elect continuation of coverage by electing continuation coverage and paying the premium due under sub. (5) (a) to either the employer or the insurer, as directed by the notice required under par. (b), within 30 days after notice is given as required under par. (a) or (c).

(5) PREMIUM. (a) The insurer may charge for coverage continued under this section an amount no more than 100% of the cost the employer incurred for providing the group policy coverage, including group rate adjustments on the date the group policy would have renewed that are based on applying rating factors to group changes that occurred prior to the discontinuance of the group policy. The employer or insurer shall collect only 35% of that amount from the terminated insured. The insurer may collect any premium subsidy available under the federal act.

(b) An insurer may require payment of premium for all required continuation coverage periods, including for periods prior to the date of election or the effective date of this rule.

(c) An employer, if requested by the insurer, shall collect and remit to the insurer premium due under this rule. An insurer may require the employer to collect and remit premium due from a terminated insured, spouse or dependent under this rule. An insurer may not condition continuation of coverage on the employer collection and remittance of premium. An insurer shall treat payment by a terminated insured, spouse or dependent to the employer as receipt and payment to the insurer unless the insurer directs that payment be made to the insurer. An insurer may direct a terminated insured, spouse or dependent to pay the premium to either the employer or to the insurer, including by direction in the notice under sub. (4) (b).

(d) An employer shall notify an insurer when the employer discontinues a group policy and does not replace the group policy. An insurer may require the employer to give it notice when it discontinues a group policy and does not replace the group policy. An insurer may not condition continuation of coverage under this rule on employer notice of such discontinuance.

(6) PORTABILITY; HIRSP. For an individual who elects continuation of coverage under

this section, the period, if any, from the date of the termination of the individual's group policy coverage to the commencement of continuation of coverage under this section shall be disregarded for the purpose of determining the 63-day period under section 632.746 (3) (b), Stats., and determining eligibility as an eligible individual ch. 149, Stats.

(7) CONTRACT TERMS PRESERVED. An insurer may restrict coverage provided under this section to the terms of the group policy to the extent the terms do not conflict with this rule. Nothing in this section prohibits an insurer from applying deductibles and other cost sharing according the terms of the group policy, including according to policy periods based on renewal dates that would have occurred had the policy not discontinued. An insurer may apply policy modifications that were included in notice given to the employer under s. 631.36. Stats., or requested by the employer, that took effect or would have taken effect prior to or on the date of the discontinuance of the policy. An insurer may include provisions for administration of this rule in its group policy and certificates.

SECTION 2. This section may be enforced under ss. 601.41, 601.64, 601.65, 628.10, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

SECTION 3. These emergency rule changes will take effect on the day after publication, as provided in s. 227.24(1)(c), Stats.

Dated at Madison, Wisconsin, this 28th day of September, 2009.

Sean Dilweg
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

for Section Ins 3.75 relating to continuation of group insurance policies and affecting small business

This rule change will have no significant negative effect on the private sector regulated by OCI but will allow numerous people to continue group health insurance that would not be able to without this change.

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

Wisconsin Department of Administration

FISCAL ESTIMATE WORKSHEET

Detailed Estimate of Annual Fiscal Effect

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 3.75**

Subject
continuation of group insurance policies and affecting small business

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

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

NET ANNUALIZED FISCAL IMPACT

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

Prepared by:	Telephone No.	Agency
Robert Luck	(608) 266-0082	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)
	(608) 267-3782	09/28/2009

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

Wisconsin Department of Administration

FISCAL ESTIMATE

☒ ORIGINAL ☐ UPDATED

☐ CORRECTED ☐ SUPPLEMENTAL

LRB Number	Amendment No. if Applicable
Bill Number	Administrative Rule Number **INS 3.75**

Subject
continuation of group insurance policies and affecting small business

Fiscal Effect

State: ☒ No State Fiscal Effect

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

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

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

☐ Decrease Costs

Local: ☒ No local government costs

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

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

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

Long-Range Fiscal Implications

None

Prepared by:	Telephone No.	Agency
Robert Luck	(608) 266-0082	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)
	(608) 267-3782	09/28/2009


FORWARD
E PLURIBUS UNUM

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

Wisconsin.gov

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E-Mail: ociinformation@wisconsin.gov
Web Address: oci.wi.gov

October 29, 2009

Members of the Legislature

Re: Emergency Rule affecting Section Ins 3.34, Wis. Adm. Code, relating to coverage of dependents to age 27 and affecting small business

Dear Senator or Representative to the Assembly:

I have promulgated the attached rule as an emergency rule. The rule will be published in the official State newspaper on October 30, 2009.

The attached copy of the rule includes the Finding of Emergency which required promulgation of the rule.

If you have any questions, please contact Julie E. Walsh at (608) 264-8101 or e-mail at julie.walsh@wisconsin.gov.

Sincerely,

Sean Dilweg
Commissioner of Insurance

SD:JW
Attachment: 1 copy rule

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

Wisconsin.gov

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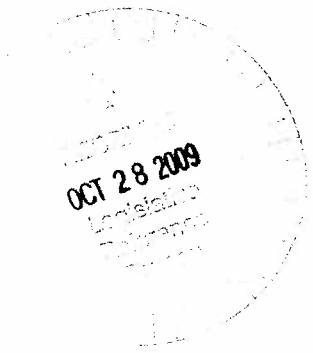

STATE OF WISCONSIN |
| SS
OFFICE OF THE COMMISSIONER OF INSURANCE |

I, Sean Dilweg, Commissioner of Insurance and custodian of the official records, certify that the annexed emergency rule affecting Section Ins 3.34, Wis. Adm. Code, relating to coverage of dependents to age 27 and affecting small business, is duly approved and adopted by this Office on October 27, 2009.

I further certify that I have compared this copy with the original on file in this Office and that it is a true copy of the original, and the whole of the original.

IN TESTIMONY WHEREOF, I have hereunto set my hand at 125 South Webster Street, Madison, Wisconsin, on October 27, 2009.

Sean Dilweg
Commissioner of Insurance

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE CREATING A RULE

To create Ins 3.34, Wis. Adm. Code,

Relating to coverage of dependents to age 27 and affecting small business.

FINDING OF EMERGENCY

The Commissioner of Insurance finds that an emergency exists and that the attached rule is necessary for the immediate preservation of the public peace, health, safety, or welfare. Facts constituting the emergency are as follows: the Commissioner is aware that insurers, employers and consumers are interpreting the state mandate inconsistently so without this rule consumers will not be treated similarly when the law becomes effective on January 1, 2010; the Commissioner has received numerous inquiries from insurers, consumers and employers seeking clarity of terms and guidance on interpretation and implementation of the law as many employers are entering open enrollment for the 2010 plan year.

These changes will be effective the day following publication in the official state newspaper and a permanent rule will start the permanent rule process to achieve uniformity in interpretation therefore protecting the public, informing employers, and guiding insurers in the state.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. **Statutes interpreted:**

   ss. 600.01, 628.34 (12), 632.885, Stats.

2. **Statutory authority:**

   ss. 600.01 (2), 601.41 (3), 601.42, 628.34 (12), Stats.

3. **Explanation of OCI's authority to promulgate the proposed rule under these statutes:**

   The commissioner is authorized by s. 601.41, Stats., to propose rules in accordance with s. 227.11 (2), Stats., in order for the commissioner to administer and enforce the insurance statutes. Since passage of 2009 Wis. Act 28, the commissioner has been made aware of dramatic differences in interpretation and approaches to implementation that necessitate rule making.

4. **Related statutes or rules:**

   None.

5. **The plain language analysis and summary of the proposed rule:**

The proposed rule interprets and implements the requirements of s. 632.885, Stats., by clarifying and defining eligibility criteria and providing guidance as to how insurers and self-insured health plans are to determine an adult child's eligibility for coverage. The proposed rule clarifies that the mandate applies to individual and group health insurance, limited-scope health insurance including vision and dental plans as well as self-insured health plans. The rule also clarifies that this mandate does not apply to certain insurance products including long-term care and Medigap policies. Further, as described in the applicability provisions of 2009 Wis. Act 28, the rule states when the mandate first applies, including the initial applicability for collectively bargained health plans.

The proposed rule provides clarity through definitions of "premium contribution" and "premium amount." The commissioner received the greatest volume of inquiries seeking guidance on how the premium comparison was to be conducted. The proposed rule simplifies and guides insurers and self-insured plans on exactly what is to be compared for this element of eligibility determination.

Guidance is provided regarding to whom an offer of coverage for an eligible adult child is to be given and reinforces the statutory provision that it is only the applicant or the insured who determines whether or not an eligible dependent is added to his or her health plan. The rule further informs insurers and self-insured plans on prohibited practices that would unduly restrict an otherwise eligible dependent from coverage contrary to the intent of the statute.

Specifically the rule provides specific guidance to insurers offering individual health insurance products as compared to insurers or self-insured health plans offering group health insurance coverage. Insurers offering individual health insurance may rate, may utilize pre-existing condition waiting periods and may apply elimination riders to an eligible adult child but may not impose such limitations as coverage would be rendered illusory. Insurers offering group health insurance or limited-scope insurance and self-insured health plans must comply with s. 632.746, Stat., with regards to pre-existing condition waiting periods and application of creditable coverage. The rule also requires insurers and self-insured health plans to treat an eligible adult child as a new entrant and provide annually at least a 30-day enrollment period.

Finally, the rule clarifies s. 632.885 (2) (a) 3. and (b) 3., Stats. An adult child is an eligible adult child when the child is between the ages of 17 and 27, is not married and who is not eligible for his or her employer sponsored coverage or whose employer does not offer health insurance to its employees. An adult child who has been called to federal active duty is an eligible adult child when a full-time student, less than 27 years of age when called to active duty. The rule clarifies that the adult child will have up to 12 months after completing active duty to apply for full-time student status at an institution of higher education, and that if the adult child is called more than once in four years of the first call to active duty, insurers and self-insured health plans may only use the adult child's age at the time of the first call to active duty when determining eligibility.

6. **Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:**

There is no existing regulation directly related to this new mandate. The federal government, US House and Senate are currently debating health insurance reform and at this time the office is aware that some of the proposals will be revised to contain similar requirements for extending coverage to adult children, but none have passed as of this date.

7. **Comparison of similar rules in adjacent states as found by OCI:**

Illinois: 215 ILCS 5/356z.12 provides parents with the option of keeping unmarried dependents on their health care insurance up to age 26. Parents with dependents who are veterans can keep dependents on the plans up to age 30. The veterans must be unmarried, must be Illinois residents, and must have received a discharge other than dishonorable. Veterans do not have to be enrolled as full-time students.

Iowa: Iowa Code § 509.3 and Iowa Code § 514E.7 requires that health insurance providers continue to cover unmarried children under their parents' coverage provided that the child: 1) is under the age of 25 and a current resident of Iowa, 2) is a full-time student, or 3) has a disability. Iowa Code § 509A.13.B, effective July 1, 2009, allows reenrollment of the same children in previously existing coverage under certain circumstances.

Michigan: No comparable regulations found. Michigan Code § 500.3406g prohibits the denial of enrollment on certain grounds for plans offering dependent coverage, and § 500.3406h addresses the eligibility of parents for dependent coverage and the health coverage of children through noncustodial parents. § 500.2264 provides exception for the termination of dependent coverage at specified age if a child is incapable of self-support due to mental or physical disability.

Minnesota: Minnesota Chapter 62E.02 Defines "dependent" as a spouse or unmarried child under age 25, or a dependent child of any age who is disabled.

Ohio: (information only) Ohio Rev. Code § 1751.14, as amended by 2009 OH H 1 allows an unmarried, dependent child who is an Ohio resident or a full-time student to remain on parent's insurance up to age 28, or without regard to age if they are incapable of self-sustaining employment due to disability.

8. **A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:**

   The commissioner reviewed existing interpretation of terms used within the new mandate that are used in other areas of the statutes and administrative code for consistency. Further the commissioner considered the intent of the mandate and proposed rules that furthered that intent.

9. **Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:**

   Although there are some limited-scope health insurers that may meet the definition of a small business, the effect on the insurers will not be significant since insurers will be able to assess and collect premium for the inclusion of the eligible adult child or may apply limitations on coverage. Intermediaries, some of whom may meet the definition of a small business will need to become familiar with this regulation but will not significantly effect those persons.

10. **See the attached Private Sector Fiscal Analysis.**

    See attached.

11. **A description of the Effect on Small Business:**

    This rule will have little or no effect on small businesses.

12. **Agency contact person:**

    A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at: **http://oci.wi.gov/ocirules.htm**

    or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: inger.williams@wisconsin.gov
Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

13. Contact information:

Mailing address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins 334
Office of the Commissioner of Insurance
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Madison WI 53707-7873

Street address:

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Web site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

SECTION 1. Ins 3.34 is created to read:

Ins 3.34 (1) PURPOSE. This section implements s. 632.885, Stats.

(2) APPLICABILITY. (a) This section applies to disability insurance policies as defined at s. 632.895 (1) (a), Stats., including individual health and group health benefit plans, and to self-insured health plans as defined at s. 632.745 (24), Stats. This section also applies to limited-scope plans including vision and dental plans but does not include hospital indemnity, income continuation, accident-only benefits, long-term care and Medigap policies.

(b) Coverage under this section first applies to policies issued or renewed on or after January 1, 2010, or for collectively bargained agreements containing provisions for health plans or policies the date the policies or plans are established, extended, modified, or renewed on or after January 1, 2010.

(3) DEFINITIONS. In this section and for purposes of applying s. 632.885, Stats.:

(a) "Adult child" means a child of the applicant, enrollee or insured who meets the eligibility requirements of s. 632.885 (2), Stats., as applicable.

(b) "Premium contribution" means the amount the adult child is required to pay for coverage under the adult child's employer sponsored group health benefit plan or self-insured health plan.

(c) "Premium amount" means the additional amount the applicant or insured is required to pay for inclusion of the adult child under the applicant's or insured's health insurance policy or self-insured plan.

(4) PREMIUM DETERMINATION. (a) To determine whether an adult child meets the eligibility standard in s. 632.885 (2) (a) 3., Stats., the insurer or self-insured health plan must use only the following:

1. The amount of the adult child's premium contribution.

2. The amount of the applicant's or insured's premium amount.

(5) OFFER OF COVERAGE. (a) Insurers and self-insured health plans shall offer to all applicants and insureds a special enrollment opportunity to include an eligible adult child as a new entrant covered under the policy or plan. It is solely the applicant's or insured's decision whether or not to add eligible adult children to the plan to the extent permitted by law.

(b) Insurers and self-insured health plans may not limit or otherwise restrict the offer of coverage to an eligible adult child by requiring any of the following:

1. The eligible adult child to have been previously covered as a dependent.

2. The eligible adult child to reside in this state.

3. The eligible adult child demonstrate that he or she had previous creditable coverage.

4. The insured or applicant to have requested coverage for an eligible adult child the first time the child was eligible for coverage.

(c) Insurers offering individual disability insurance must also comply with the following:

1. Insurers may not deny coverage to an eligible adult child when the applicant or insured requests coverage.

2. Insurers may individually rate the eligible adult child and apply pre-existing condition waiting periods compliant with s. 632.76 (2) (ac) 2., Stats.

3. Insurers may apply elimination riders to the eligible adult child.

4. Insurers may not otherwise limit coverage if such limitations result in coverage that is illusory.

(d) Insurers offering group disability insurance and self-insured health plans must also comply with the following:

1. Insurers and self-insured health plans may not deny coverage of an eligible adult child when coverage is requested by the applicant or insured.

2. Insurers and self-insured health plans must apply portability rights to an eligible adult child so long as the adult child has not had a break in creditable coverage longer than 62 days.

3. Insurers and self-insured health plans must comply with s. 632.746, Stats., as applicable.

4. Insurers and self-insured health plans shall offer coverage for eligible adult children of applicants and insureds as new entrants and shall annually provide at least a 30-day enrollment period. In 2010, the 30-day enrollment period shall occur at the time the policy is issued or renews. Insurers may request documentation of the adult child's creditable coverage for determining portability. The pre-existing condition waiting period applicable to the eligible adult child must be applied to the adult child the same as any other applicant or eligible dependent.

(6) ELIGIBLE ADULT CHILD. (a) For purposes of this section and implementation of s. 632.885 (2), Stats., an adult child is eligible for coverage as a dependent if either of the following is met:

1. For an adult child who has not been called to federal active duty in the national guard or in a reserve component of the U.S. armed forces, either of the following:

a. An adult child who meets s. 632.885 (2) (a) 1. and 2., Stats., and who is not eligible for his or her employer sponsored coverage or whose employer does not offer health insurance to its employees is an eligible adult child.

2. For an adult child who has been called to federal active duty in the national guard or in a reserve component of the U.S. armed forces, all of the following:

a. The adult child must apply to an institution of higher education as a full-time student within 12 months from the date the adult child has fulfilled his or her active duty obligation.

b. When an adult child is called to active duty more than once within a four-year period of time, the insurer and self-insured health plan must use the adult child's age when first called to active duty for determining eligibility under this section.

SECTION 2. This section may be enforced under ss. 601.41, 601.64, 601.65, 628.10, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

SECTION 3. These emergency rule changes will take effect on the day following publication as provided in s. 227.24 (1) (c), Stats.

Dated at Madison, Wisconsin, this 28 day of October, 2009.

Sean Dilweg
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

for Section Ins 3.34 relating to coverage of dependents to age 27 and affecting small business

This rule change will have no significant effect on the private sector regulated by OCI.

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

Wisconsin Department of Administration

FISCAL ESTIMATE WORKSHEET

Detailed Estimate of Annual Fiscal Effect

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 334**

Subject
coverage of dependents to age 27 and affecting small business

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

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

NET ANNUALIZED FISCAL IMPACT

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

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Authorized Signature:	Telephone No.	Date (mm/dd/ccyy)

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

Wisconsin Department of Administration

FISCAL ESTIMATE

☒ ORIGINAL ☐ UPDATED

☐ CORRECTED ☐ SUPPLEMENTAL

LRB Number	Amendment No. if Applicable
Bill Number	Administrative Rule Number **INS 334**

Subject
coverage of dependents to age 27 and affecting small business

Fiscal Effect

State: ☒ No State Fiscal Effect

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

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

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

☐ Decrease Costs

Local: ☒ No local government costs

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

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

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

Long-Range Fiscal Implications

None

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