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# CLEARINGHOUSE RULE 96–186

## Comments

**[NOTE: All citations to "Manual" in the comments below are to the Administrative Rules Procedures Manual, prepared by the Revisor of Statutes Bureau and the Legislative Council Staff, dated October 1994.]**

***1. Statutory Authority***

a. Section Ins 8.63 relates to a requirement that insurers offer coverage to late enrollees. It does not incorporate the provisions of s. 632.747, Stats., as created by 1995 Wisconsin Act 289 (Act 289), which relate to covering an employe who waived coverage previously. These provisions should be incorporated in the rule.

Moreover, s. 632.747 (2), Stats., specifies the circumstances under which certain late enrollees (that is, those who previously waived coverage) must be provided coverage. When s. 632.747, Stats., applies, the restrictions in s. Ins 8.63 (2) allowing coverage for late enrollees to be totally excluded for up to 18 months (and permitting a requirement that an individual remain employed for the period of exclusion) or allowing the application of a preexisting conditions exclusion are contrary to the provisions of s. 632.747 (2), Stats., which do not allow for such an exclusion period or a preexisting conditions exclusion.

b. Section 632.745 (1) (f) 1., Stats., as created by Act 289, defines "qualifying coverage," and indicates that it means "benefits ***or coverage*** provided under any of the following . . ." (emphasis added). Section Ins 8.66 (2) indicates that, for the purpose of s. 632.745, Stats., an individual has previous qualifying coverage with respect to a particular service if the previous policy, certificate or other benefit arrangement covering the individual was qualifying coverage ***and*** provided any benefit with respect to the service. This could be interpreted to mean, for example, that a service offered by a health maintenance organization (HMO) through a group health benefit plan is not considered to be qualifying coverage with respect to that particular service unless the HMO previously provided a benefit with respect to

that service. This is contrary to s. 632.745 (1) (f) 1., Stats., which does not require that a benefit must have been previously provided with respect to a particular service.

This problem might be solved if the last part of s. Ins 8.66 (2) read as follows: ". . . if the individual's previous policy, certificate or other benefit arrangement was qualifying coverage and provided any benefit or coverage with respect to the service."

c. As renumbered and amended, s. Ins 8.66 (5) will provide that "[a]n insurer shall administratively comply with s. 632.745 (1) (f), Stats., for all policies in force on or after July 1, 1993, with respect to qualifying coverage defined under s. 632.745 1. a., b. and c. (sic, see comment 4. e., below) for all individuals who commence coverage under a policy after June 30, 1993." Because Act 289 provides an effective date of May 1, 1997 with respect to its group health insurance market reforms, there is no statutory authority for making this statement with respect to all insurers. If this statement was intended to be limited to small employer insurers, this must be specifically stated.

d. Act 289 provides that the ***effective date*** for the group health insurance market reform provisions is May 1, 1997. [SECTION 279 (2t) of Act 289.] However, Act 289 includes an ***initial applicability*** provision for these reforms. Specifically, Act 289 provides that, with one exception, the group health insurance market reform provisions that affect group health benefit plans first apply to group health benefit plans that are issued or renewed "on the effective date of this paragraph." [SECTION 278 (2t) (a) of Act 289.] According to SECTION 279 (1) of Act 289, the paragraph in question, that is, the paragraph in SECTION 278 of Act 289, takes effect on the day after publication, that is, on May 10, 1996. As for the exception, Act 289 provides that its provisions first apply to group health benefit plans that cover employes who are affected by a collective bargaining agreement containing provisions inconsistent with Act 289 that are issued or renewed on the earlier of the following: (1) the day on which the collective bargaining agreement expires; or (2) the date on which the collective bargaining agreement is extended, modified or renewed. [SECTION 278 (2t) (b) of Act 289.]

In contrast, the rule provides an ***effective date*** of "the first day of the first month after publication," rather than May 1, 1997. Moreover, the rule includes an ***initial applicability*** provision which specifies that the "rule first applies on May 1, 1997." This initial applicability provision fails to take into account that Act 289 specifies that its provisions ***first apply*** to group health benefit plans that are ***issued or renewed*** after a certain date or, if the exception with respect to group health benefit plans covering employes affected by a collective bargaining agreement containing inconsistent provisions applies, that its provisions first apply on the earlier of the following: (1) the day on which the collective bargaining agreement expires; or (2) the date on which the collective bargaining agreement is extended, modified or renewed.

The effective date and initial applicability provisions of the rule must be made consistent with the effective date and initial applicability provisions of Act 289.

***2. Form, Style and Placement in Administrative Code***

a. Act 289 provided, in general, that certain provisions of prior law relating to preexisting conditions limitations or exclusions, portability, prohibited coverage practices,

guaranteed acceptance, policy cancellation and policy renewability no longer applied only to small employer health insurance but, instead, were to be applied, in pertinent part, to all "group health benefit plans," as defined in s. 632.475 (1) (c), Stats. According to the analysis, the rule, in general, extends these provisions to "the self-employed, and to employers of 26 or more employes as required by Act 289." The following comments apply:

(1) Almost all of the provisions in the rule relate to all group health benefit plans, not small employer health insurance plans alone. The rule includes provisions which affect all group health benefit plans by intermingling them with other provisions in ch. Ins 8, subch. III, which is entitled "Small Employer Health Insurance." The title of ch. Ins 8, subch. III, is unchanged by the rule.

Given the title of subch. III, it is unlikely that an individual who is concerned about group health benefit plans that are not small employer health insurance plans will be aware of the existence of these provisions--especially given the fact that no other provisions in the chapters dealing with group health insurance cross-reference the subch. III provisions which are not limited to small employer health insurance plans.

Moreover, the statement in s. Ins 8.44 (1) that "certain provisions of this subchapter where noted apply to all employers" is not sufficient to provide notice to the reader of the pertinent provisions--especially since no provision in subch. III explicitly notes which provisions apply to all group health benefit plans or apply only to small employer health insurance plans. Rather, a reader will be forced to read all of subch. III and, presumably, is expected to decipher which sections apply to all group health benefit plans rather than small employer health insurance plans by virtue of the fact that some provisions refer to employers versus small employers.

In summary, as currently structured and titled, placement of these provisions in subch. III alone is inappropriate. It would be preferable to reorganize the material in order to consolidate the provisions in this rule that are applicable to all group health benefit plans. Suggestions for reorganization include creating a new subchapter in ch. Ins 8 or creating one or more sections in ch. Ins 3 (which includes other provisions pertinent to group health benefit plans). An appropriate cross-reference to the newly created provisions could be added in s. Ins 8.44 (1) so that it is clear which provisions apply to small employer health insurance plans.

(2) Although the analysis indicates that the rule applies to the self-employed, it is not clear how the rule does so.

b. In SECTION 2 of the rule, the title to s. Ins 8.44 should not be shown. [See s. 1.05 (3) (d), Manual.] This comment also applies to the title to s. Ins 8.66 in SECTION 16.

c. In SECTION 3 of the rule, the title to s. Ins 8.46 should be written in solid capital letters and underscored. [See s. 1.05 (2) (b), Manual.] This comment also applies to the title to s. Ins 8.67 in SECTION 22.

d. In SECTION 6 of the rule, the title to s. Ins 8.54 (1) should be written in solid capital letters. [See s. 1.05 (2) (c), Manual.] This comment also applies to the title to s. Ins 8.54 (2) in SECTION 7.

e. In SECTION 8 of the rule, the title to s. Ins 8.54 (3) should be written in solid capital letters, as it will appear, without showing strike-throughs or underscoring. Also, the notation "(title)" should be included in the treatment clause and inserted before the amended title. [See s. 1.05 (2) (c) and (3) (a) and (c), Manual.]

f. In SECTION 10 of the rule, the title to s. Ins 8.59 should be written in solid capital letters and underscored, as it will appear, without showing strike-throughs or underscoring. Also, the notation "(title)" should be included in the treatment clause and inserted before the amended title. [See s. 1.05 (2) (b) and (3) (a) and (c), Manual.] This comment also applies to the title to s. Ins 8.60 in SECTION 11, the title to s. Ins 8.61 in SECTION 12, the title to s. Ins 8.63 in SECTION 13, the title to s. Ins 8.64 in SECTION 14 and the title to s. Ins 8.65 in SECTION 15.

g. In s. Ins 8.46 (2), paragraphs 1. to 6. should be labeled as paragraphs (a) to (f). [See s. 1.03 (4), Manual.]

h. SECTION 11 of the rule should have dealt only with provisions affected by the rule, not all of s. Ins 8.60. Thus, it should have indicated that: "Ins 8.60 (title), (1) (intro.) and (c) and (2) are amended to read:". The text of sub. (1) (a), (b), (d) and (e) should not have been included inasmuch as no changes were indicated as having been made to those paragraphs. This comment applies throughout the rule; unaffected provisions of current rules should not be shown. Also, entire subunits of a rule should not be repealed by striking. For example, see s. Ins 8.59 (4).

i. SECTION 16 should have indicated that "Ins 8.66 (1) (intro.) is amended to read", rather than referring to s. Ins 8.66 (1) (a).

j. SECTION 18 indicates that s. Ins 8.66 (3) is repealed and recreated. The following SECTION, which was unnumbered but, presumably, was intended to be SECTION 19, indicates that s. Ins 8.66 (3) is renumbered and amended. Section Ins 8.66 (3) cannot be both.

It is recommended that SECTION 18 be used to create s. Ins 8.66 (2m) to include the language provided in SECTION 18; no underscoring should be used. In this way, the renumbering of s. Ins 8.66 (3), (4) and (5) in SECTIONS 19, 20 and 21 can be avoided.

k. Section Ins 8.66 (6) refers to "subs. (1) to ~~(3)~~ ~~(4)~~." The "(4)" should not be both stricken-through and underscored. [See s. 1.06 (1), Manual.] It was apparently meant to be underscored.

***4. Adequacy of References to Related Statutes, Rules and Forms***

a. Section Ins 8.42 provides definitions for use in ch. Ins 8, subch. III, which s. Ins 8.42 (intro.) indicates are in addition to the definitions in "s. 635.02, Stats." (Although not an issue in the current rule review, it appears that the reference in the current rule should have been to

"ss. 635.02 and 635.20, Stats.," as the latter section includes definitions specific to the small employer health insurance plan.) It appears that s. Ins 8.42 (intro.) should also cross-reference the definitions in s. 632.745 (1), Stats., because those terms are also used in the rule.

b. Current s. Ins 8.40 indicates that ch. Ins 8, subch. III, "interprets and implements ch. 635, Stats., and s. 619.12 (2) (e), Stats." The proposed rule did not propose amending s. Ins 8.40, even though the analysis to the rule indicates that the rule interprets ss. 600.01, 628.34 (12), 632.745, 632.76, 632.747, 632.896 and 635.11, Stats. If the content of the rule is retained in ch. Ins 8, subch. III, then s. Ins 8.40 should be amended to include references to all of the statutes interpreted.

c. Section Ins 8.54 (2) (d) provides that an insurer that intends to terminate a policy under "s. 632.749 (a) to (c) or (3), Stats.," must comply with certain notice requirements. It appears that the first cite should be to s. 632.749 (1) (a) to (c), Stats. With respect to the cite to s. 632.749 (3), Stats., that subsection merely indicates that s. 632.749, Stats., does not apply if the insurer is in liquidation. This cite does not appear to be needed or appropriate.

d. In s. Ins 8.59 (3) (c), it appears that the reference to the "basic health benefit plan as determined under s. Ins 8.66 (1)" is incorrect. Should the reference be to the basic health benefit plan described in ch. Ins 8, subch. IV, relating to the basic health benefit plan for small employers? This comment also applies to s. Ins 8.60 (1) (a).

e. As amended, the first sentence of s. Ins 8.66 (5) will refer to "qualifying coverage defined in s. 632.745 (1), Stats., in addition to qualifying coverage defined in s. 632.745 (f), Stats." The first cite should refer specifically to s. 632.745 (1) (f) 1., Stats. The second cite is incomplete as currently drafted and appears to be unnecessary in light of the first cite.

In addition, in the second sentence of s. Ins 8.66 (5), the reference to s. "632.745 1. a., b. and c., Stats." should be to s. "632.745 (1) (f) 1. a., b. and c., Stats."

f. It appears that the rule should have amended several references in current rules to s. 635.17, Stats., a section that was repealed by Act 289. Those references are in the following provisions:

(1) Section Ins 8.62 (3) (c), relating to preexisting conditions exclusions in the basic health benefit plan for small employers, which indicates that a preexisting conditions exclusion is allowed under certain circumstances if the exclusion complies with s. 635.17 (1), Stats.

(2) Section Ins 8.63 (2), which indicates that an insurer may not impose a preexisting conditions exclusion under s. 635.17 (1), Stats., in addition to the exclusion permitted under s. Ins 8.63 (2).

(3) Section Ins 8.75 (1), relating to preexisting conditions exclusions in the basic health benefit plan for small employers, which indicates that s. 635.17 (1), Stats., applies to such plans.

(4) Section Ins 3.31 (3) (a) 4. a., relating to preexisting conditions limitations in group plans, which indicates that preexisting conditions limitations permitted under s. 635.17 (1), Stats., are allowed.

(5) Section Ins 3.28 (6) (a), relating to preexisting conditions limitations in individual plans, which indicates that preexisting conditions limitations permitted under s. 635.17 (1), Stats., are allowed.

***5. Clarity, Grammar, Punctuation and Use of Plain Language***

a. Section Ins 8.44 (1) provides that "certain provisions of this subchapter where noted apply to all employers." However, certain provisions of subch. III do not apply to all employers but, rather, apply to group health benefit plans issued by insurers to employers.

b. In the last sentence of s. Ins 8.46 (2) (intro.), it appears that the phrase "~~A small~~ An employer insurer" should be changed to "~~A small employer~~ An insurer."

c. In s. Ins 8.46 (2) 1. [sic (see comment 2. g., above)], it appears that the phrase "70% of the group" should be changed to "70% of the eligible employes." This change would avoid use of the undefined term "group" and would make s. Ins 8.46 (2) 1. [sic] consistent with s. Ins 8.46 (2) 2. to 6. [sic], each of which uses the defined term "eligible employes."

d. In s. Ins 8.54 (1), the addition of the sentence "However, small employer insurers must comply with the premium rate restrictions specified in s. Ins 8.52 (3)." seems unnecessary in light of the statement in the previous sentence that insurers have the right to change premiums "subject to the premium rate restrictions specified in s. Ins 8.52 (3)." It is suggested that the underlined sentence quoted above be deleted and that the following change be made in the previous sentence: "subject to the premium rate restrictions specified in s. Ins 8.52 (3) for small employer insurers."

e. Section Ins 8.54 (3) provides that if an insurer ceases to renew "policies," then the insurer may not issue a "group health benefit plan" during the five-year period beginning with the latest expiration date for a "policy" that is not renewed.

In the definition of "policy" in s. Ins 8.42 (9), "group health benefit plan" is a subset of the set defined as "policy"; thus, they are not identical terms. The term "group health benefit plan" is defined in s. 632.745 (1) (c), Stats. However, as noted in comment 4. a., above, the definitions in s. 632.745 (1), Stats., have not been incorporated into this rule. In the statutory definition of "group health benefit plan," certain individual health benefit plans are included. These individual health plans are not the same as the subset of individual health plans described in the definition of "policy" set forth in s. Ins 8.42 (9) (b).

Under s. 632.749 (2) (c), Stats., nonrenewal is allowed if certain requirements are met, including the requirement that the insurer not issue a "group health benefit plan" before five years after the nonrenewal of "group health benefit plans." Because of the difference in terminology between the statutes and the rule, the rule would allow certain individual health plan benefits to be issued during this five-year period even though this would not be allowed under the statutes if the individual health benefit plan were a plan covering eligible employes when three or more are sold to an employer. This problem should be corrected. Moreover, it is recommended that the rule be reviewed to try to reconcile the definition of "group health benefit plan" in s. 632.475 (1) (c), Stats., with various provisions in the rule.

f. Section Ins 8.60 (1) (a) to (e) limit the circumstances under which an insurer may permit an individual to decline coverage in the initial enrollment period, including, under s. Ins 8.60 (1) (d), cases in which the individual is not enrolled in the Health Insurance Risk-Sharing Plan "and the annualized premium contribution to be paid by the eligible employe on behalf of the employe or the dependent of the employe would exceed 10% of the annualized gross earnings of the eligible employe from the employer."

This means that if the premium contribution to be paid by the employe is less than 10% of earnings, the insurer could not accept an employe's declination of coverage on that basis. Assuming another reason for declination did not exist, this would appear to force an employe to accept and pay for coverage that he or she might not want as long as the contribution level is less than 10% of earnings. Is this intended?

g. In the second sentence in s. Ins 8.63 (2), is the reference to "small employer" intended?

h. In s. Ins 8.66 (2), the phrase "and individual" should be "an individual."

i. In s. Ins 8.66 (4), are the references to "small employer insurer" intended? If so, who has the responsibility to gather any needed information if an insurer is not a small employer insurer?

j. Section Ins 8.66 (6) provides that "[a]n insurer, on request, shall provide to the current insurer of a small employer copies of pertinent health plan provisions . . . to enable the current insurer to comply with subs. . . . ." Is the reference to small employer intended? If so, who has the responsibility to provide information, upon request, to the current insurer of an employer who is not a small employer?

k. Section Ins 8.67 first specifies that a restrictive rider, endorsement or other provision that would violate s. 632.745 (5) (b) 1., Stats., that is in force on May 1, 1997, may not remain in force beyond the first renewal date of the policy. Section Ins 8.67 then specifies that "an insurer shall delete the rider, endorsement or other provision after May 1, 1997." These two provisions may conflict with each other. Was it intended that the latter provision require the insurer to delete the rider, endorsement or other provision at the time of the first renewal that occurs on or after May 1, 1997? This should be clarified.