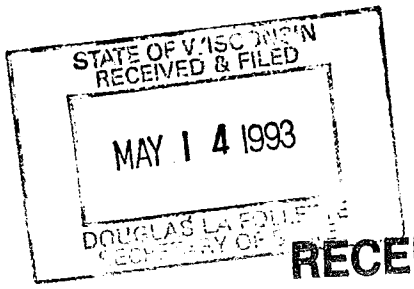
CR 92-217



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STATE OF WISCONSIN)
)
OFFICE OF THE COMMISSIONER OF INSURANCE)

I, Josephine W. Musser, Commissioner of Insurance and custodian of the official records of this office, certify that the attached rule-making order affecting subch. IV of ch. Ins 8, Wis. Adm. Code, relating to establishing a basic benefit plan for small employers, was issued by this office on May 14, 1993.

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 whole of the original.

Dated at Madison, Wisconsin, this 14 day of May 1993.

Josephine W. Musser
Commissioner of Insurance

38776T

7-1-93

ORDER OF THE SMALL EMPLOYER INSURANCE BOARD AND

THE OFFICE OF THE COMMISSIONER OF INSURANCE

CREATING A RULE

To create subch. IV of ch. Ins 8, relating to establishing a basic health benefit plan for small employers.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3), 635.23, 635.254 and 635.29, Stats.

Statutes Interpreted: subch. II of ch. 635, Stats.

1991 Wisconsin Act 250 requires health insurers to actively market health insurance coverage, including a basic health benefit plan (basic plan) to small employers (employers with 2 to 25 employes). An insurer must also offer a basic plan to any small employer whose application for coverage under one of the insurer's regular plans is rejected because of claims experience or health status of the group. The act creates a small employer insurance board (plan board) consisting of 5 representatives of small employers who are eligible to purchase a basic plan and 5 representatives of employes of

eligible employers. The commissioner of insurance (commissioner) or his or her designee is the permanent nonvoting chairperson of the board.

The plan board has the responsibility to create, by administrative rule subject to the commissioner's approval, the provisions of the basic plan including the basic benefits that must be offered, the extent to which the basic plan must comply with statutorily mandated benefits, the minimum benefit standards, employer eligibility requirements, limitations on probationary or waiting periods and enrollment periods. The plan board may also establish other plan features by rule.

This rule specifies the benefits that a basic plan must cover. These specified benefits are consistent with benefits generally offered to employers in the small group market. A basic plan must cover medically necessary care and treatment including routine and emergency medical care and surgery, inpatient and outpatient hospital care, treatment in an ambulatory surgery center, prenatal and obstetrical care, chiropractic treatment, dental care for accidental injuries, nursing home and hospice care, ground ambulance service, prescription drugs, durable medical equipment and supplies, well baby care, immunizations and vaccinations, x-rays and diagnostic tests, physical therapy and certain organ transplants.

The plan board has the authority to limit but not to exclude coverage for any condition for which coverage is required under Wisconsin insurance law. The basic plan limits the mandate for treatment of mental illness and alcohol and other substance abuse. The statute requires health insurance policies to cover inpatient, outpatient and transitional treatment services for those conditions with an annual cap of $7,000. This rule imposes an annual benefit cap of $1,400 for treatment of those conditions.

The rule permits an insurer to apply to its basic plan the definitions, limitations and exclusions that are generally applicable to other group health insurance policies it offers in the small employer market.

The rule establishes a schedule of mandatory copayments. A preferred provider plan may modify these copayments as necessary to implement its managed care plan. No copayment is required for prenatal care visits and well baby care, including immunizations, from birth to 24 months. There is also no copayment for professional services provided in a hospital or ambulatory surgery center, in addition to the copayment for use of the facility.

The maximum annual calendar year benefit payable for an insured individual under a basic plan is $30,000. The proposed rule requires an insurer to pay 80% of the covered charges that exceed the copayments up to $5,000, until the insurer has paid out $4,000, and 95% of additional covered charges until the $30,000 annual maximum benefit has been paid. The insured is responsible for the rest of the provider's charges. Insurers are prohibited from imposing additional copayments, coinsurance or an annual deductible on a basic plan.

A closed panel health maintenance organization may use either copayments or coinsurance instead of both if the effect is the actuarial equivalent of the total of the required copayments and coinsurance.

The plan board also has the responsibility of establishing employer eligibility requirements for participation in a basic plan and determining whether participating employers may impose a probationary or waiting period on employes who become eligible after the commencement of the small employer's coverage. The rule requires a small employer insurer to offer a basic plan to any small employer meeting the statutory definition even if the small employer has fewer employes than the number usually required for participation in other group plans which the insurer offers in the small employer market. The rule

limits the participation requirements that an insurer may impose on a small employer. If the group of eligible employes has more than 10 people without other health insurance, the insurer may not impose a participation requirement of more than 70%. The participation requirement limits for groups of 10 and under are stated as absolute numbers (e.g., for a group of 8 eligible employes without other health insurance, an insurer may not require more than 5 participants).

The rule also permits an insurer to require that new employes enroll within 30 days after becoming eligible. Insurers must permit an eligible employe or dependent whose coverage under another health benefit plan terminates for any reason to enroll in the small employer's basic plan without medical underwriting within 30 days after the termination of the other coverage.

Under the applicable law, an employe of a small employer is eligible to participate in a plan if he or she works on a full-time basis and has a normal work week of 30 or more hours. Part-time, temporary and substitute workers are not defined as eligible employes. An insurer that issues a basic plan to a small employer may limit participation to eligible employes and their dependents or may also offer coverage to other employes. If other employes are permitted to enroll in the basic plan the small employer is not obligated to pay a percentage of the premium as is required for full-time employes. The small employer is, however, required to withhold the full amount of the premium from the earnings of that employe.

The rule also includes provisions on rating basic plans. In establishing new business premium rates, an insurer is prohibited from taking into account the actual or anticipated experience of the basic plan separately from the experience of all of its other small employer health benefit plans.

In rating a small employer's basic plan, the insurer must apply a higher rate to smokers than to nonsmokers, and the rate must reflect the cost of providing coverage to smokers as opposed to nonsmokers, as required by 1991 Wisconsin Act 310. Act 310 also requires that individuals who are rated differently must be given a written statement specifying the premium rate differential used by the insurer. Small employer insurers are required to provide copies of the rating statements for distribution to plan participants.

A small employer insurer that offers managed care plans (e.g., health maintenance organizations, preferred provider organizations) in the small employer market must offer at least one managed care option to purchasers of a basic plan.

The rule requires insurers to submit their basic plan policy forms to the office of the commissioner of insurance within 2 months after the effective date of the rule (the first day of the month after publication). Insurers that are required to issue basic plans may not market any health benefit plans to small employers unless their basic plan policy forms are approved within 4 months after the rule's effective date.

SECTION 1. Subchapter IV of chapter Ins 8 is created to read:

CHAPTER INS 8

SUBCHAPTER IV

BASIC HEALTH BENEFIT PLAN FOR SMALL EMPLOYERS

Ins 8.70 PURPOSE. This subchapter implements subch. II of ch. 635, Stats., by establishing the basic health benefit plan that small employer insurers shall actively market and offer to small employers.

Ins 8.71 DEFINITIONS. (1) The definitions in ss. 635.02 and 635.20, Stats., apply to this subchapter.

(2) In this subchapter, "health care provider" means any of the following:

(a) A medical or osteopathic physician, podiatrist, physical therapist or physician's assistant licensed or certified under ch. 448, Stats.

(b) A psychologist licensed under ch. 445, Stats.

(c) A chiropractor licensed under ch. 446, Stats.

(d) A nurse midwife certified under s. 441.15, Stats.

(e) A nurse practitioner licensed under ch. 441, Stats.

(f) A nurse licensed under ch. 441, Stats., who is certified as a nurse anesthetist by the American association of nurse anesthetists.

(g) A dentist licensed under ch. 447, Stats.

Ins 8.72 BASIC BENEFITS. Subject to the limitations and restrictions under s. Ins 8.75 and copayments and coinsurance under s. Ins 8.77, each plan shall provide coverage for all of the following, if medically necessary:

(1) Professional services by a health care provider acting within the scope and limitations of his or her license or certificate or a person acting under the direction of a health care provider, including all of the following:

(a) Office, outpatient, inpatient and emergency room visits including treatment rendered during those visits.

(b) Surgical services including postoperative care following inpatient or outpatient surgery.

(c) Services of an assistant surgeon if necessary to perform surgery.

(d) Anesthesia services.

(2) Hospital care, including all of the following:

(a) Semi-private room, board and ancillary services and supplies that are generally provided to hospital inpatients.

(b) Confinement in an intensive care or coronary care unit of a hospital.

(c) Outpatient medical care and treatment.

(d) Medical care and treatment provided in a hospital emergency room.

(3) Medical care and treatment provided in an ambulatory surgery center, as defined in s. 49.45 (6r) (a) 1, Stats.

(4) Outpatient x-ray, laboratory and other diagnostic tests.

(5) Confinement in a skilled nursing home licensed under subch. I of ch. 50, Stats.

(6) Services provided by a home health agency licensed under s. 141.15, Stats.

(7) Care provided by a hospice licensed under subch. IV of ch. 50, Stats.

(8) Local ground licensed ambulance services.

(9) Physical therapy.

(10) Rental and purchase of durable medical equipment and supplies.

(11) Prescription drugs.

(12) Reconstructive surgery which is either of the following:

(a) Incidental to or following surgery necessitated by illness or injury.

(b) Caused by a congenital disease or anomaly of a covered dependent child which results in a functional defect.

(13) Sterilization.

(14) Maternity services including all of the following:

(a) Prenatal services normally associated with pregnancy.

(b) Delivery services normally associated with a vaginal or caesarean section delivery.

(c) Routine nursery care from the moment of birth until the infant is discharged from the hospital.

(15) Complications of pregnancy.

(16) Inpatient, outpatient and transitional treatment for nervous and mental disorders and alcoholism and other drug abuse, subject to s. Ins 8.75 (3).

(17) Preventive services appropriate to the age and sex of the covered person including all of the following:

(a) Routine physical examinations and health screening tests.

(b) Immunizations for poliomyelitis, diphtheria, pertussis, typhoid, measles, mumps and rubella.

(c) Vaccinations for hemophilus influenza, type B.

(d) Diphtheria and tetanus boosters.

(e) Influenza and pneumonia vaccinations.

(f) Tuberculosis skin tests.

(18) Organ transplants that are covered by medicare.

(19) Services provided by a dentist for the repair of accidental dental injuries.

Ins 8.73 HEALTH INSURANCE MANDATES. A plan shall comply with the health insurance mandates, as defined in s. 601.423, Stats., and may not exclude or limit coverage for any mandate except as provided in s. Ins 8.75 (3).

Ins 8.74 POLICY TITLE; TERM. (1) The policy form for a plan submitted to the office of the commissioner of insurance for approval under s. 631.20, Stats., shall be entitled "basic health benefit plan."

(2) The term period for plan coverage shall not be less than 12 months.

Ins 8.75 LIMITATIONS AND RESTRICTIONS. (1) PREEXISTING CONDITIONS. Section 635.17 (1), Stats., applies to a plan subject to this subchapter.

(2) ANNUAL MAXIMUM. The annual calendar year maximum benefit for a plan is $30,000 per insured individual. Charges for a hospitalization which extends from one calendar year to another shall be subject to the calendar year maximum for the year in which each charge was incurred and only one $75 copayment shall apply to the confinement.

(3) LIMITATION ON COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT. The annual calendar year benefit payable for treatment of a covered person for nervous and mental disorders and alcoholism and other drug abuse is $1,400. A plan may not apply the cost of outpatient prescription drugs used in the treatment of nervous and mental disorders or alcoholism or other drug abuse toward the annual limit specified in this subsection.

Ins 8.76 POLICY TERMS; EXCLUSIONS; LIMITATIONS. (1) Except as otherwise provided in this subchapter, a plan's policy terms shall be defined consistently with the definitions in the small employer insurer's other small group health benefit plans.

(2) A plan may exclude from coverage or limit coverage for specified conditions and services other than those required under s. Ins 8.72 but may exclude or limit only those conditions and services which are generally excluded from coverage or limited under the small employer insurer's other small group health benefit plans.

(3) A plan may apply the same limitations on provider choice, coverage and geographical service area that apply under the small employer insurer's other small group health benefit plans.

Ins 8.77 COPAYMENTS; COINSURANCE. (1) DEFINITIONS. In this section:

(a) "Primary care provider" means any of the following:

1. If the plan is an indemnity plan, a preferred provider organization or health maintenance organization that does not require the

insured to designate a primary provider, the physician who normally provides care to the insured, if the physician is any of the following:

a. A physician who is not certified by any specialty board.

b. A physician certified by the American board of family practice.

c. A physician certified by the American board of internal medicine.

d. A physician certified by the American board of obstetrics and gynecology.

e. A physician certified by the American board of pediatrics.

2. If the plan is a health maintenance organization that requires an insured to designate a primary provider, the physician designated.

(b) "Specialist" means any physician other than a primary care provider.

(2) COPAYMENTS. (a) Except as provided in par. (b), sub. (3) and s. Ins 8.79, a copayment in the specified amount applies each time an insured receives any of the following:

1. Professional services from a primary care provider or from a specialist who is consulted with a referral from a primary care provider when provided during an office visit or on an outpatient basis in a hospital, ambulatory surgery center or approved treatment facility, as defined in s. 51.01 (2), Stats.: $25.

2. Professional services from a specialist when provided during an office visit or on an outpatient basis in a hospital, ambulatory surgery center or approved treatment facility, as defined in s. 51.01 (2), Stats., when the specialist is consulted without a referral from a primary care provider: $35.

3. Professional services from a chiropractor: $11.

4. Ambulance service, unless immediately admitted to the hospital: $75.

5. Treatment in a hospital emergency room, unless immediately admitted to the hospital: $75.

6. Inpatient hospitalization: $100.

7. Prescription drugs, proprietary: $20 or the cost of the prescription, whichever is less.

8. Prescription drugs, generic: $10, or the cost of the prescription, whichever is less.

(b) The copayments specified in par. (a) 1 and 2 do not apply to professional services in connection with prenatal care or well baby care from birth to 24 months.

(2) COINSURANCE. Except as provided in sub. (3) and s. Ins 8.79, for each insured individual, a plan shall pay the following portions of the amount by which covered charges in a calendar year exceed the copayments:

(a) For all charges other than for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems:

1. 80% of the first $5,000 of charges until the plan has paid $4,000.

2. 95% of the remainder of charges until the plan limit under s. Ins 8.75 (2) has been met.

(b) For the treatment of nervous or mental disorders or alcoholism or other drug abuse problems, 80% of the charges until the plan has paid $1,400 or the plan limit under s. Ins 8.75 (2) has been met.

(3) EXCEPTION FOR HEALTH MAINTENANCE ORGANIZATIONS. A plan offered by a health maintenance organization that requires participants to use only specified health care providers may elect to offer either copayments or coinsurance if the amount for which a participant is responsible is the

actuarial equivalent of the copayments and coinsurance required under subs. (1) and (2). Upon request, a health maintenance organization shall provide the office of the commissioner of insurance with sufficient documentation to support its determination of actuarial equivalence.

(4) DEDUCTIBLES AND OTHER COST-SHARING PROHIBITED. A plan shall not include an annual deductible or any copayment or coinsurance requirement other than those specified in this section, except as provided in s. Ins 8.79.

Ins 8.78 PARTICIPATION; ENROLLMENT. (1) PARTICIPATION. (a) A small employer insurer shall offer a plan to any small employer meeting the definition of eligible employer in s. 635.20 (2), Stats., regardless of the number required for participation in other small group health benefit plans offered by the small employer insurer.

(b) In par. (c), the number of persons in a group means the number of eligible employes without other qualifying coverage, as defined in s. 635.02 (5m), Stats.

(c) A small employer insurer may impose participation requirements on a plan offered to a small employer, not to exceed the following:

1. For a group of more than 10 persons: 70% of the group.

2. For a group of 10 persons: 6 participants.

3. For a group of 8 or 9 persons: 5 participants.

4. For a group of 7 persons: 4 participants.

5. For a group of 5 or 6 persons: 3 participants.

6. For a group of 2 to 4 persons: 2 participants.

(2) PROBATIONARY PERIOD. A small employer may impose a waiting period of not more than 90 days from the date of hire before a new employe is eligible to enroll in the small employer's plan.

(3) ENROLLMENT. (a) A plan may require that new employes of a small employer and newly eligible dependents enroll in the plan within 30 days after becoming eligible to enroll.

(b) An eligible employe or dependent whose coverage under another health insurance plan terminates for any reason may enroll in a small employer's plan without medical underwriting within 30 days after termination of the other coverage.

(4) EMPLOYER CONTRIBUTION EXCEPTION. (a) A plan may limit coverage to eligible employes, as defined in s. 635.20 (1m), Stats., and their dependents.

(b) If a plan permits employes other than those defined as eligible employes in s. 635.20 (1m), Stats., to enroll, the small employer is not required to pay the employer contribution specified under s. 635.254 (1), Stats., for those employes. If the small employer elects not to contribute, the small employer shall withhold the entire amount of the premium from the earnings of each employe permitted to participate, as provided in s. 635.254 (2), Stats.

Ins 8.79 MANAGED CARE OPTIONS. A small employer insurer that offers health benefit plans with one or more managed care options in the small employer market shall offer purchasers of a basic health benefit plan at least one managed care option. If the option offered is a preferred provider plan, as defined under s. 609.01 (4), Stats., the small employer insurer, in order to encourage the use of health care providers that participate in the plan, may increase any copayment specified in s. Ins 8.77 (1) or the percentage of an insured's coinsurance under s. Ins 8.77 (2) if the insured uses a nonparticipating health care provider.

Ins 8.80 RATING. (1) In establishing the new business premium rate for the plan, a small employer insurer shall take into account the experience of all of its small employer health benefit plans. The differences between the plan's new business premium rate and the insurer's new business premium rates for all other small employer health benefit plans shall be based solely on the differences in the plan designs and not on the actual or anticipated experience of those insured under the basic health benefit plan.

(2) (a) 1. Except as provided in par. (b), the plan shall apply a higher rate to smokers than to nonsmokers. The rate applied to smokers shall be no higher than permitted under s. 111.35 (3), Stats. The small employer insurer shall provide the small employer with enough copies of the statements required under s. 111.35 (3) (a) 2 and (b) 2, Stats., for distribution to all plan participants.

2. For the purpose of complying with s. 635.05, Stats., and s. Ins 8.52, smoking status shall be treated as a case characteristic.

(b) Paragraph (a) does not apply to a health maintenance organization federally qualified under title 13 of the public health service act.

Ins 8.81 FORM APPROVAL AND MARKETING. (1) Except as provided in s. 635.26 (2m) to (4), Stats., each small employer insurer shall file its basic health benefit plan policy form with the commissioner of insurance under s. 631.20, Stats., before the first day of the 3rd month beginning after the effective date of this rule (revisor inserts date).

(2) Except as provided in s. 635.26 (2m) to (4), Stats., no small employer insurer shall market any health benefit plan to small employers on and after the first day of the 5th month beginning after the effective date of this rule (revisor inserts date) unless its basic health benefit plan policy form has been filed with and approved by the commissioner of insurance under s. 631.20, Stats.

SECTION 2. EFFECTIVE DATE. This rule will take effect on the first day of the first month after publication, as provided in s. 227.22 (2) (intro.), Stats.

Dated at Madison, Wisconsin, this 14 day of May 1993.

Josephine W. Musser

Josephine W. Musser
Commissioner of Insurance

774R15
05/14/93

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Josephine W. Musser
Commissioner

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May 26, 1993

GARY POULSON
DEPUTY REVISOR OF STATUTES
131 W WILSON STE 800
MADISON WI 53703-3233

Re: Clearinghouse Rule No. 92-217

Dear Mr. Poulson:

In proofreading this rule, I discovered an error in s. Ins 8.75 (2), Wis. Adm. Code, and I would appreciate it if you would correct the error prior to publication by substituting "$100" for "$75" in the text.

The error occurred when, during the legislative review process, the Small Employer Insurance Board and the Office of the Commissioner of Insurance were directed to make modifications in the proposed rule. One of the changes involved revising and simplifying the schedule of copayments, including an increase in the copayment for inpatient hospitalization from the recommended $75 to $100. The change was made in the schedule itself, s. Ins 8.77 (2) (a) 6, Wis. Adm. Code, but the reference to that copayment in s. Ins 8.75 (2), Wis. Adm. Code, was not corrected.

I am enclosing a copy of the corrected page. Thank you for your assistance. Please contact me if you have any questions.

Sincerely,

Mary Alice Coan

Mary Alice Coan
Attorney

MAC:mle
Enclosure
39173T

(12) Reconstructive surgery which is either of the following:

(a) Incidental to or following surgery necessitated by illness or injury.

(b) Caused by a congenital disease or anomaly of a covered dependent child which results in a functional defect.

(13) Sterilization.

(14) Maternity services including all of the following:

(a) Prenatal services normally associated with pregnancy.

(b) Delivery services normally associated with a vaginal or caesarean section delivery.

(c) Routine nursery care from the moment of birth until the infant is discharged from the hospital.

(15) Complications of pregnancy.

(16) Inpatient, outpatient and transitional treatment for nervous and mental disorders and alcoholism and other drug abuse, subject to s. Ins 8.75 (3).

(17) Preventive services appropriate to the age and sex of the covered person including all of the following:

(a) Routine physical examinations and health screening tests.

(b) Immunizations for poliomyelitis, diphtheria, pertussis, typhoid, measles, mumps and rubella.

(c) Vaccinations for hemophilus influenza, type B.

(d) Diphtheria and tetanus boosters.

(e) Influenza and pneumonia vaccinations.

(f) Tuberculosis skin tests.

(18) Organ transplants that are covered by medicare.

(19) Services provided by a dentist for the repair of accidental dental injuries.

Ins 8.73 HEALTH INSURANCE MANDATES. A plan shall comply with the health insurance mandates, as defined in s. 601.423, Stats., and may not exclude or limit coverage for any mandate except as provided in s. Ins 8.75 (3).

Ins 8.74 POLICY TITLE; TERM. (1) The policy form for a plan submitted to the office of the commissioner of insurance for approval under s. 631.20, Stats., shall be entitled "basic health benefit plan."

(2) The term period for plan coverage shall not be less than 12 months.

Ins 8.75 LIMITATIONS AND RESTRICTIONS. (1) PREEXISTING CONDITIONS. Section 635.17 (1), Stats., applies to a plan subject to this subchapter.

(2) ANNUAL MAXIMUM. The annual calendar year maximum benefit for a plan is $30,000 per insured individual. Charges for a hospitalization which extends from one calendar year to another shall be subject to the calendar year maximum for the year in which each charge was incurred and only one $100 copayment shall apply to the confinement.

(3) LIMITATION ON COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT. The annual calendar year benefit payable for treatment of a covered person for nervous and mental disorders and alcoholism and other drug abuse is $1,400. A plan may not apply the cost of outpatient prescription drugs used in the treatment of nervous and mental disorders or alcoholism or other drug abuse toward the annual limit specified in this subsection.

Ins 8.76 POLICY TERMS; EXCLUSIONS; LIMITATIONS. (1) Except as otherwise provided in this subchapter, a plan's policy terms shall be defined consistently with the definitions in the small employer insurer's other small group health benefit plans.