

Chapter Ins 8

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Subchapter I — Employee Welfare Funds

Ins 8.01 Receipt of payments from funds by parties-in-interest. (1) Section 641.19 (2), Stats., prohibits certain persons who are or may be in a position to influence the operations of an employee welfare fund from engaging in certain transactions with such fund or which affect such fund directly or indirectly. The parties to whom the prohibition is directed are the trustees of the fund, the participating employers, the labor organizations representing any employees covered by the fund, and the officers, agents and employees of such trustees, employers and labor organizations. One of the prohibitions placed upon such parties is the receipt of any payment, commission, loan, service or any other thing of value from the fund or which is charged against the fund or would otherwise be payable to the fund, either directly or indirectly. This prohibition does not extend to the receipt of benefits from the fund by any such party who is entitled thereto under the plan nor does the statute prohibit a trustee or officer, agent or employee from receiving from the fund reasonable compensation for necessary services and expenses rendered or incurred in connection with official duties in respect to the fund.

Note: Section 641.19, Stats., was repealed by 2003 Wis. Act 261.

(2) The prohibition applied to receipts by the specified parties from the fund. The penalties for engaging in a transaction prohibited by s. 641.19 (2), Stats., would be enforceable against the persons named therein rather than against the fund. Accordingly it may be said that s. 641.19 (2), Stats., does not govern investments

by a fund but rather governs the specified parties in their dealings with a fund.

Note: Section 641.19, Stats., was repealed by 2003 Wis. Act 261.

(3) The law does not prohibit the trustees of a fund from investing fund monies in any certain way but it does prohibit trustees and other specified persons who may be in a position to influence the transactions of a fund from using their positions to enrich themselves at the expense of a fund either directly or indirectly. At the same time, the law does not alter the duty of trustees clearly established in other laws, both statutory and common, to manage funds exclusively for the purpose of providing the employee benefit promised.

(4) At the time of the enactment of this law, transactions between funds and participating employers, employees and labor organizations were an established practice. The internal revenue code of the United States recognizes that many such transactions may be entered into without impairing the tax status of such funds. Many of the trust agreements under which such funds are established and maintained specifically authorize the trustees to engage in such transactions on behalf of the funds. We do not interpret the law to prohibit all such transactions. What is prohibited is the receipt by any specified party of a payment, commission, loan, service or any other thing of value from a fund under such circumstances that at least an equivalent value in money's worth is not received by the fund from such person as a part of such transaction.

Note: In the following examples the receipt of a valuable consideration by the party as specified would not appear to be prohibited in the stated circumstances. These examples are not intended to be all-inclusive.

1. Receipt from a fund by a participating employer or labor organization of reasonable compensation for the fair value of necessary services rendered to the fund or for the actual cost of necessary expenses incurred for or on behalf of the fund.

2. Receipt from a fund by a participating employer or labor organization of payment for necessary real property or equipment sold or leased to the fund for use in the operations of the fund in an amount not in excess of the fair market value of such property or equipment at the date of sale or the fair rental value at the date of lease. Any facts known to such an employer or labor organization which would influence such market or rental value must necessarily be considered in determining the fair value at such date.

3. Purchase or lease of real estate or equipment from a fund by a participating employer or labor organization if such purchase or lease is made at arms-length on such terms and conditions as would be required at such time by an independent financial institution or other business organization engaged in such transactions which has knowledge of all facts pertinent thereto which are known by such employer or labor organization. If the terms and conditions required by such organizations cannot be established, the terms and conditions should be equivalent to those which would be granted by any independent vendor or lessor having knowledge of all pertinent facts known to such employer or labor organization and considering both the probable income and probable safety of his or her capital.

4. Receipt by a participating employer or labor organization of a loan from a fund if such loan is made at arms-length according to such terms and conditions, including the rate of interest and duration of the loan and the nature and amount of security pledged therefor, as would be required at such time by an independent financial institution or other business organization engaged in making such loans which has knowledge of all facts pertinent thereto which are known by such employer or labor organization.

5. Receipt by a participating employee of a loan from a fund if such loan would meet the requirements of a loan to a participating employer or labor organization as specified in example 4. above.

6. Purchase of securities or other investments from a fund by a participating employer or labor organization if made for not less than an adequate consideration to the fund. An "adequate consideration" means the price which would be paid at such time by an independent buyer having knowledge of all facts pertinent thereto which are known to such employer or labor organization. Such value may be established by an impartial appraisal of the investment if such value cannot be established by reference to bid and asked prices or by reference to sales prices.

7. Sale of securities or other investments to a fund by a participating employer or labor organization if made for not more than an adequate consideration as defined by example 6. above.

8. Purchase from or sale to a fund by a participating employer of its capital stock in if accord with conditions described in examples 6. and 7. above.

History: Cr. Register, August, 1960, No. 56, eff. 9-1-60; am. (1) and (2), Register, November, 1978, No. 275, eff. 12-1-78; corrections made under s. 13.93 (2m) (b) 5., Stats., Register, April, 1992, No. 436.

Ins 8.02 "Trust fund or other fund", definition. (1) A "trust fund or other fund" constituting an employee welfare fund subject to ch. 641, Stats., exists where a trustee or trustees, a committee, or other party is designated jointly by one or more employers together with one or more labor organizations, solely by any employer or labor organization, or jointly by employers, or jointly by labor organizations to provide employee benefits a) under an agreement describing their responsibilities and duties, and b) from monies or other property under their control specifically segregated to provide such employee benefits.

Note: Chapter 641, Stats., was repealed by 2003 Wis. Act 261.

(2) A fund, program or plan of employee benefits under which benefits are paid to participants directly out of the general funds of an employer or labor union without the actual segregation of monies or other assets to meet liabilities for benefits does not operate through means of a "trust fund or other fund". This is true although a balance sheet reserve account may be maintained for such estimated liabilities. A common plan of such type is a plan of continuation of wages in the event of sickness or accident.

(3) A fund, program or plan of employee benefits in which all benefits are provided through insurance contracts issued to an employer or labor union under which premiums are paid out of the general funds of such employer or union directly to the insurance carrier without the interposition of trustees or a fund, although employees may contribute through payroll deductions or otherwise, does not operate through means of a "trust fund or other fund".

(4) Under certain forms of insurance or annuity contracts available to pension plans, insurers guarantee that benefits will be paid to participants only to the extent that a fund or account held by them will be sufficient to provide them. Under such contracts, amounts are paid to the insurer for credit to a deposit or accumulation account. The balance in this account is held as a deposit subject to future determinations by the policyholder as to its disposition. Deposit administration contracts with variations thereof, such as immediate participation guarantees, are a common form of contract under which such unallocated funds or accounts are

held. Also unallocated funds may be held to supplement or convert, at retirement, reserves under other forms of insurance or annuity contracts. This is common under forms of life or group permanent contracts. Funds, programs or plans of employee benefits which provide benefits through such unallocated funds or accounts held by insurers operate through a "trust fund or other fund". Such funds, programs or plans constitute employee welfare funds under the law irrespective of the parties and methods through which premiums are paid under sub. (3).

(5) A fund, program, or plan of employee benefits operating under a custodian or trust agreement under which a custodian receives employer contributions and purchases shares in an investment trust or other similar arrangement of pooling moneys for investment purposes constitutes an employee welfare fund if:

(a) The custodian holds such shares for the fund, program, or plan pending receipt of distribution instructions to be received when a participant in the plan qualifies for a benefit distribution, and

(b) The employer contributing to the plan determines when an employee is to be enrolled under the plan and qualifies for a benefit distribution.

(6) Where a trust or fund receives contributions from more than one employer and these contributions are commingled for investment purposes, a separate employee welfare fund exists for each employer segment of the trust if separate computations or allocations are made to each employer segment of the trust for the benefit cost, insurance experience, or gains from forfeited benefits arising from participants.

(7) Where a trust or fund is established by one employer to hold moneys for 2 or more employee benefit plans for different groups of employees of that employer, one fund exists if all the assets of the trust or fund are available for benefit payments under any of the plans. Where separate accounting is required to be maintained by the trustee, so that only a designated portion of the total trust is available for benefit payments under each plan, an employee welfare fund exists for each plan portion of the trust or fund.

History: Cr. Register, July, 1962, No. 79, eff. 8-1-62; cr. (4), (5), (6), Register, October, 1968, No. 154, eff. 11-1-68; am. title, (1) (a), (b), (c) and (d); r. (2) intro. and (a); renum. (2) (b) to be (2), (2) (c) to be (3); r. (2) (d); renum. (3) to be (4) and am.; renum. (4), (5), and (6) to be (5), (6) and (7), Register, December, 1970, No. 180, eff. 1-1-71; am. (1), Register, November, 1978, No. 275, eff. 12-1-78; correction made under s. 13.93 (2m) (b) 5., Stats., Register, April, 1992, No. 436.

Ins 8.03 "Employee benefits", definition. (1) The term "employee benefits" under s. 641.07 (2), Stats., must be broadly construed. The definition covers both benefits and services. Section 641.07 (2), Stats., declares that the type of benefits covered by the law are not limited to those specifically enumerated therein.

Note: Section 641.07, Stats., was repealed by 2003 WisAct 261.

(2) Section 641.07 (2), Stats., enumerates 4 classes of benefits as being among the forms of benefits covered by the law. These are:

Note: Section 641.07, Stats., was repealed by 2003 WisAct 261.

(a) Medical, surgical or hospital care or benefits.

(b) Benefits in the event of sickness, accident, disability or death.

(c) Benefits in the event of unemployment.

(d) Retirement benefits.

(3) Other types of benefits commonly offered to employees which are covered by the law include:

(a) Deferred benefits from profit-sharing savings or stock bonus plans.

(b) Benefits upon termination of employment.

(c) Vacation benefits.

History: Cr. Register, July, 1962, No. 79, eff. 8-1-62; am. (1) and (2), Register, November, 1978, No. 275, eff. 12-1-78.

Ins 8.04 Registration requirements. (1) Every employee welfare fund within the meaning of s. 641.07 (1), Stats.,

must be registered with the commissioner of insurance within 3 months after the first day on which coverage is provided for any person employed in Wisconsin. For purposes of computing the time in which to register a fund in which the plan is back-dated or provides coverage to participants retroactively, the plan should be construed to provide coverage as of the date of its formal establishment.

Note: Section 641.07, Stats., was repealed by 2003 WisAct 261.

(2) Registration shall be made on form No. 71-3. A fund which covers more than 25 persons employed in Wisconsin at the time of registration must file a copy of the following documents, if applicable, as a part of such registration:

- (a) Plan, as amended to date
- (b) Trust indenture, as amended to date
- (c) Any separate contract or other instrument under which the fund is administered
- (d) Collective bargaining agreement(s), or provisions thereof relating to the fund, as currently in force
- (e) Any booklet or other written material descriptive of the fund which is given or made available to employees

(3) An employee welfare fund which does not cover more than 25 persons employed in Wisconsin at the time of registration is not required to submit copies of fund documents when registered; however, if subsequently it provides coverage to more than 25 persons employed in Wisconsin, the fund documents must be submitted with the annual statement for the first year in which more than 25 persons employed in Wisconsin are covered.

History: Cr. Register, July, 1962, No. 79, eff. 8-1-62; am. (1), Register, November, 1978, No. 275, eff. 12-1-78.

Ins 8.05 Registration cancellation. When a registered employee welfare fund is merged or consolidated with another fund, or is terminated, or ceases to cover any person employed in Wisconsin, the trustee of such fund must file written notice of such action with the commissioner of insurance within 30 days after its occurrence. Such notice shall be verified by the oath of the trustee of the fund, or if there is more than one trustee, then by the oaths of at least 2 trustees. If more than 25 persons employed in Wisconsin were covered by such fund, the notice shall include a certified true copy of the resolution of the trustees or of the board of directors of the employer or similar authority under which such action was taken.

History: Cr. Register, July, 1962, No. 79, eff. 8-1-62.

Ins 8.06 Annual statement and notice of number of fund participants in Wisconsin, when required. (1) An annual statement on form No. 71-9 must be filed under s. 641.13, Stats., by the trustee of every employee welfare fund subject to ch. 641, Stats., for each fiscal year of the fund during which coverage is provided to more than 25 persons employed in Wisconsin. The annual statement must be filed within 5 months after the close of the fiscal year of the fund.

Note: Ch. 641, Stats., was repealed by 2003 WisAct 261.

(2) The trustee of every employee welfare fund subject to ch. 641, Stats., within 5 months after the close of its first fiscal year during which less than 26 persons employed in Wisconsin were covered, must file a written notice with the commissioner of insurance that less than 26 persons employed in Wisconsin participated in the fund during such year. Such notice will remain in effect for all subsequent years until the first year thereafter during which more than 25 persons employed in Wisconsin participate at any time. The filing of a notice under this rule does not relieve the trustee of a fund from the responsibility to file an annual statement for any year during which more than 25 persons employed in Wisconsin participate in the fund. If an annual statement must be filed for any year after a notice has been filed, the procedure of filing a notice will again apply for the first year thereafter during which coverage is provided to less than 26 persons employed in Wisconsin.

Such renewed notices shall have the same force and effect as an initial notice.

Note: Chapter 641, Stats., was repealed by 2003 Wis. Act 261.

(3) When an employee welfare plan which covers more than 25 persons employed in Wisconsin is terminated and fund assets are completely distributed or paid over to another fund, an annual statement must be filed under s. 641.13, Stats., within 5 months after the date of final distribution of the fund. Such annual statement must report the affairs of the fund from the date of the last previous annual statement and must reflect the final accounting of the fund for the transfer or distribution of all its assets.

Note: Ch. 641, Stats., was repealed by 2003 WisAct 261.

(4) When an employee welfare plan is terminated but assets are held for distribution at a later date, the fund remains subject to ch. 641, Stats., as long as at least one Wisconsin employee participates. Annual statements must be filed by the trustee of any such fund for every year in which more than 25 persons employed in Wisconsin participate at any time. Notice under sub. (2) must be given for the first fiscal year in which less than 26 persons employed in Wisconsin participate. Notice of termination of the fund must be given in accordance with s. Ins 8.05.

Note: Chapter 641, Stats., was repealed by 2003 Wis. Act 261.

History: Cr. Register, July, 1962, No. 79, eff. 8-1-62; am. Register, November, 1978, No. 275, eff. 12-1-78.

Ins 8.07 "Persons employed in this state". The term "persons employed in this state" as used in ch. 641, Stats., includes both active employees in Wisconsin and retired or terminated persons participating in the fund who were employed in Wisconsin at the time of retirement or other separation. The term includes anyone whether or not a resident of Wisconsin, who is employed at a place of business maintained by an employer in the state of Wisconsin; however, an employee who is not regularly employed at a place of business maintained by an employer shall be deemed to be employed in Wisconsin if service is performed solely within Wisconsin, or if service is performed partly within Wisconsin and partly outside of Wisconsin and

Note: Chapter 641, Stats., was repealed by 2003 Wis. Act 261.

(1) The service outside of Wisconsin is incidental to service within Wisconsin (for example, is occasional, temporary or transitory in nature) or

(2) The base of operations is in Wisconsin, or

(3) If there is no base of operations, then the place from which the service is directed or controlled is in Wisconsin.

Note: Example: A seller who spends 20% of the hours of employment in Wisconsin and who works from a base of operations in Wisconsin would be "employed in this state". A seller who spends 50% of the hours of employment in Wisconsin but who works from a base of operations outside of Wisconsin would not be "employed in this state". A seller whose service is performed primarily in Wisconsin (service outside of the state is only occasional) is "employed in this state" even though the base of operations is in another state or is directed or controlled from another state.

History: Cr. Register, July, 1962, No. 79, eff. 8-1-62; am. (intro.), Register, November, 1978, No. 275, eff. 12-1-78; correction made under s. 13.93 (2m) (b) 5., Stats., Register, April, 1992, No. 436.

Ins 8.08 Availability of information to fund participants. The following information shall be available to all fund participants, including covered employees and their beneficiaries, contributing employers and participating labor organizations, in the office of the fund at all reasonable hours: (In the case of a fund which is administered solely by an employer or union, a separate fund office may not be maintained. In such case the following information must be available at the principal office of the employer or union in this state.)

(1) Copy of registration statement under s. 641.08, Stats., including all current fund documents specified by such statement. A fund which covers less than 26 persons employed in Wisconsin must maintain such documents although it is not required to file them with the commissioner of insurance under s. Ins 8.04.

Note: Section 641.08, Stats., was repealed by 2003 WisAct 261.

(2) Copies of annual statements under s. 641.13, Stats., for the 3 latest fiscal years.

Note: Section 641.13, Stats., was repealed by 2003 WisAct 261.

(3) Copy of latest report of examination of the fund by the commissioner of insurance.

History: Cr. Register, July, 1962, No. 79, eff. 8-1-62; am. (1) and (2), Register, November, 1978, No. 275, eff. 12-1-78.

Ins 8.09 Preservation of records. The trustee of every employee welfare fund subject to ch. 641, Stats., shall maintain the books and records of such fund in sufficient detail to permit a thorough examination of the operations of such fund by the commissioner of insurance for a period of 5 years after the close of the fiscal year of such fund in which the entries in such books or records are made. Such books and records shall include all journals, ledgers, checks, vouchers, invoices, receipts, bank statements, minutes, resolutions, agreements, contracts and other records of original or final entry. The preservation of photographic reproductions of such records shall constitute compliance with the requirements of this rule.

Note: Chapter 641, Stats., was repealed by 2003 Wis. Act 261.

History: Cr. Register, July, 1962, No. 79, eff. 8-1-62; am. Register, November, 1978, No. 275, eff. 12-1-78.

Ins 8.10 Advisory council on employee welfare plans. **History:** Cr. Register, July, 1970, No. 175, eff. 8-1-70; am. (4)(a) and (b), Register, November, 1978, No. 275, eff. 12-1-78; corrections made under s. 13.93 (2m) (b) 5., Stats., Register, April, 1992, No. 436; **CR 08-064: r. Register December 2008 No. 636, eff. 1-1-09.**

Ins 8.11 County and school district self-insured employee health care benefits: excess or stop-loss insurance requirements. (1) **PURPOSE.** This section interprets ss. 59.52 (11) (c) and 120.13 (2) (c), Stats., for the purpose of prescribing detailed requirements for excess or stop-loss insurance for self-insured employee health care benefit plans provided by counties or school districts.

(2) **SCOPE.** This section applies to any county or school district that alone or together with one or more counties or one or more school districts provides employee health care benefits on a self-insured basis to less than 1,000 covered employees.

(3) **DEFINITIONS.** In this section:

(a) "Aggregate claims" means total actual claim amounts incurred under the employee health care benefit plan during a benefit period.

(b) "Aggregate deductible" means the aggregate amount of liability specified in the excess or stop-loss insurance contract at or below which the county or school district remains liable for payments for eligible claims.

(c) "Benefit period" means a twelve-month accounting or reporting period of the employee health care benefit plan.

(d) "Coinsurance" means a fixed percentage of each claim established in the employee health care benefit plan which the county or school district is obligated to pay for each person covered in the plan.

(e) "Covered employees" means employees participating in an employee health care benefit plan.

(f) "Employees eligible to participate" means employees who are eligible to be covered employees under the terms of the employee health care benefit plan.

(g) "Employee health care benefit plan" means a self-insured plan established by one county or school district or jointly by 2 or more counties or 2 or more school districts to provide health care benefits to employees eligible to participate in the plan.

(h) "Expected claims" means the most accurate actuarial estimate of aggregate claims during a benefit period.

(i) "Incurred" means to have provided or furnished a service or item to an employee or dependent covered under an employee health care benefit plan for which a charge for a covered expense is made.

(j) "Maximums" means the largest total amount of claims per person established by the employee health care benefit plan which the county or school district is obligated to pay.

(k) "Paid basis" means the application of a claim payment to the aggregate deductible for the benefit period in which the payment is actually made, regardless of when the claim is incurred.

(L) "Quota share reinsurance" means insurance purchased for the employee health care benefit plan which pays the plan a predetermined fixed percentage of each claim.

(4) **EXCESS OR STOP-LOSS INSURANCE REQUIREMENTS.** (a) Excess or stop-loss insurance required by s. 120.13 (2) (c), Stats., shall provide coverage for all claims incurred during the term of the policy or contract at a level at which an actuary has certified that the probability that aggregate claims will exceed 125% of expected claims is less than 5%.

(b) Each employee health care benefit plan shall be covered by one excess or stop-loss insurance policy that satisfies par. (a), regardless of the number of counties or school districts participating in the plan.

(c) Notwithstanding par. (a), a county or school district that self-insures employee health benefits under a plan in which an actuary has certified that the probability that aggregate claims will exceed 125% of expected claims is less than one-half percent need not purchase excess or stop-loss insurance.

(5) **EXCESS OR STOP-LOSS INSURANCE PROVIDED ON A PAID BASIS.** (a) Excess or stop-loss insurance required by s. 120.13 (2) (c), Stats., may provide coverage on a paid basis.

(b) Upon termination for any reason of an excess or stop-loss insurance policy that provides coverage on a paid basis, the policy shall apply all claims incurred but not paid prior to the termination of the policy to the aggregate deductible of the benefit period in which the service or item was provided or furnished to an employee or dependent under the self-insured employee health care benefit plan.

(6) **ACTUARIAL CERTIFICATION.** (a) Every county or school district with a plan that is subject to s. 120.13 (2) (c), Stats., shall file with the commissioner of insurance within 30 days after the effective date of the self-insured employee health care benefit plan, every 3 years thereafter and whenever a material change occurs to the plan, an actuarial certification that includes information on:

1. The number of employees eligible to participate in the plan and the number of covered employees in the plan.

2. A description of the plan's coverage including but not limited to an outline of benefits provided, deductibles, coinsurance, maximums and quota share reinsurance, if any.

3. A statement that the plan satisfies the excess or stop-loss insurance requirements specified in sub. (4).

4. Except for a county or school district with a plan subject to s. 641.08, Stats., a copy of the excess or stop-loss insurance contract and of the plan for self-insuring.

Note: A county or school district with a plan subject to ch. 641, Stats., must already file this information with the commissioner.

Note: Chapter 641, Stats., was repealed by 2003 Wis. Act 261.

(b) The actuarial certification required in par. (a) may be filed by an actuary employed by the excess or stop-loss insurer or by an actuary independent of the excess or stop-loss insurer.

(c) Two or more counties or 2 or more school districts that jointly establish an employee health care benefit plan shall designate the individual who will file the actuarial certification required in par. (a). Only one actuarial certification shall be filed for the plan.

Note: The commissioner of insurance will utilize the following tables to evaluate actuarial certifications for accuracy and compliance with this section. The following example illustrates the application of the tables. This example only gives a basic description of how to use the following tables. It may be necessary to extrapolate or interpolate from the information given in the tables in order to apply the tables to a particular plan. An actuary or other qualified person should be consulted to be certain that a plan meets the requirements of sub. (4). Also note that no table provides a

description of dental or vision plan benefits. Under sub. (4) (c), many dental or vision plans may not need to purchase stop-loss insurance.

Example

Assume a school district has a self-insured employee health care benefit plan that covers 250 employees and family members. The plan offers individual specific stop-loss of \$25,000 and provides benefits with a \$500.00 deductible per person, 80% coinsurance and \$1,000.00 out-of-pocket limit per person.

The plan's stop-loss coverage and benefit package are the same as that used in Table 7. Therefore, use Table 7 for determining whether the plan meets the requirements in sub. (4).

In Table 7, use the 125 percent of mean line. Since sub. (4) (a) deals with "125% of expected claims," refer to the 125% of mean line when using any of the tables.

To determine whether the probability that aggregate claims will exceed 125% of expected claims is less than 5%, subtract the decimal numbers shown in the tables from the number "1". For example, for a plan offering the benefits described in Table 7 and having 25 employees, the probability that aggregate claims will exceed 125% of expected claims is 28% (1 minus .72 = .28). It is 26% for 50 employees (1 minus .74), 23% for 100 employees (1 minus .77), etc.

In this example, the plan covers 250 employees. Table 7 shows that at 250 employees, the probability that aggregate claims will exceed 125% of expected claims is 18% (1 minus .82).

In order to comply with the rule, this probability must be less than 5%. In this example, the probability is 18%. Therefore, the school district or county must purchase aggregate stop-loss insurance at a level sufficient to bring this probability down to less than 5%. Stop-loss insurance is sold at various levels, including a level at which the probability that aggregate claims will exceed 125% of expected claims is less than 5%. At a minimum, the school district or county should purchase stop-loss insurance at this level.

Table 8.11-1

STATE OF WISCONSIN

Distribution of Medical Claim Individual Specific Stop Loss

Level: \$5,000

July 1, 1987

Probability that Medical Claims are Less Than a Given Percent of Mean

\$0 Deductible, 100 Percent Coverage

Percent of Mean	Employees				
	100	250	500	1,000	5,000
50%	.04	.01	.00	.00	.00
75	.19	.14	.06	.01	.00
100	.53	.52	.51	.51	.51
105	.60	.61	.63	.70	.86
110	.67	.69	.74	.84	.96
115	.73	.77	.83	.92	.99
120	.78	.83	.89	.97	1.00
125	.83	.87	.94	.99	1.00
130	.86	.90	.96	1.00	1.00
150	.95	.98	1.00	1.00	1.00

Table 8.11-2

STATE OF WISCONSIN

Distribution of Medical Claim Individual Specific Stop Loss

Level: \$10,000 July 1, 1987 Probability that Medical Claims

are Less Than a Given Percent of Mean \$0 Deductible, 100

Percent Coverage

Percent of Mean	Employees				
	100	250	500	1,000	5,000
50%	.05	.01	.00	.00	.00
75	.21	.14	.06	.01	.00
100	.53	.52	.52	.51	.51
105	.60	.61	.63	.69	.85
110	.66	.69	.74	.83	.96
115	.72	.76	.83	.91	.99
120	.77	.82	.89	.96	1.00
125	.82	.86	.93	.99	1.00
130	.85	.90	.96	1.00	1.00
150	.94	.98	1.00	1.00	1.00

Table 8.11-3

STATE OF WISCONSIN

Distribution of Medical Claim Individual Specific Stop Loss

Level: \$25,000 July 1, 1987 Probability that Medical Claims

are Less Than a Given Percent of Mean \$0 Deductible, 100

Percent Coverage

Percent of Mean	Employees				
	100	250	500	1,000	5,000
50%	.06	.01	.00	.00	.00
75	.24	.15	.07	.01	.00
100	.54	.53	.53	.52	.52
105	.60	.61	.63	.68	.83
110	.66	.70	.73	.82	.95
115	.71	.75	.81	.90	.99
120	.76	.80	.87	.95	1.00
125	.80	.85	.92	.98	1.00
130	.83	.89	.95	.99	1.00
150	.92	.97	1.00	1.00	1.00

Table 8.11-4

STATE OF WISCONSIN

Distribution of Medical Claim Individual Specific Stop Loss

Level: Unlimited July 1, 1987 Probability that Medical

Claims are Less Than a Given Percent of Mean \$0

Deductible, 100 Percent Coverage

Percent of Mean	Employees				
	100	250	500	1,000	5,000
50%	.07	.02	.00	.00	.00
75	.29	.19	.10	.02	.00
100	.59	.56	.56	.55	.53
105	.63	.63	.64	.68	.80
110	.69	.70	.73	.79	.93
115	.73	.75	.80	.87	.98
120	.76	.79	.85	.92	1.00
125	.80	.84	.89	.95	1.00
130	.83	.87	.92	.97	1.00
150	.91	.95	.98	1.00	1.00

Table 8.11-5

STATE OF WISCONSIN

Distribution of Medical Claim Individual Specific Stop

Loss Level: \$5,000 July 1, 1987 Probability that Medical

Claims are Less Than a Given Percent of Mean \$500

Deductible Per Person, 80% Percent Coinsurance \$1,000

Out-of-Pocket Limit Per Person

Percent of Mean	Employees					
	25	50	100	150	250	500
50%	.22	.13	.06	.05	.01	.00
75	.39	.32	.23	.21	.16	.07
100	.57	.55	.53	.52	.52	.52
105	.60	.60	.60	.60	.61	.63
110	.63	.64	.66	.66	.69	.73
115	.66	.68	.71	.72	.76	.81
120	.69	.72	.76	.77	.81	.88
125	.72	.74	.80	.82	.85	.92
130	.74	.77	.83	.84	.89	.95
150	.82	.87	.92	.94	.97	1.00

Table 8.11-6

STATE OF WISCONSIN

Distribution of Medical Claim Individual Specific Stop Loss Level: \$10,000 July 1, 1987 Probability that Medical Claims are Less Than a Given Percent of Mean \$500 Deductible Per Person, 80% Percent Coinsurance \$1,000 Out-of-Pocket Limit Per Person

Percent of	Employees					
	25	50	100	150	250	500
Mean	.25	.16	.07	.05	.02	.00
50%	.42	.34	.25	.23	.17	.08
75	.58	.55	.55	.53	.53	.53
100	.60	.60	.60	.60	.61	.63
105	.64	.64	.65	.66	.68	.73
110	.67	.67	.70	.72	.74	.80
115	.70	.71	.75	.76	.79	.86
120	.71	.74	.78	.80	.84	.91
125	.74	.77	.82	.84	.89	.94
130	.81	.85	.91	.93	.96	.99

Table 8.11-7

STATE OF WISCONSIN

Distribution of Medical Claim Individual Specific Stop Loss Level: \$25,000 July 1, 1987 Probability that Medical Claims are Less Than a Given Percent of Mean \$500 Deductible Per Person, 80% Percent Coinsurance \$1,000 Out-of-Pocket Limit Per Person

Percent of	Employees					
	25	50	100	150	250	500
Mean	.29	.19	.08	.06	.02	.00
50%	.47	.39	.30	.26	.19	.10
75	.61	.58	.56	.55	.54	.53
100	.64	.61	.61	.61	.61	.63
105	.66	.64	.65	.66	.67	.71
110	.68	.68	.70	.70	.73	.78
115	.70	.70	.73	.74	.79	.85
120	.72	.74	.77	.79	.82	.89
125	.74	.76	.80	.82	.86	.93
130	.80	.83	.89	.92	.95	.99

Table 8.11-8

STATE OF WISCONSIN

Distribution of Medical Claim Individual Specific Stop Loss Level: Unlimited July 1, 1987 Probability that Medical Claims are Less Than a Given Percent of Mean \$500 Deductible Per Person, 80% Percent Coinsurance \$1,000 Out-of-Pocket Limit Per Person

Percent of	Employees					
	25	50	100	150	250	500
Mean	.35	.24	.12	.09	.04	.00
50%	.53	.53	.37	.32	.25	.15
75	.67	.66	.61	.59	.58	.57
100	.69	.68	.65	.64	.64	.64
105	.71	.71	.68	.68	.69	.72
110	.72	.72	.72	.72	.73	.78
115	.74	.75	.75	.75	.77	.83
120	.76	.76	.78	.79	.81	.87
125	.77	.78	.80	.81	.84	.90
130	.82	.84	.88	.89	.92	.96

(7) ACTUARY QUALIFICATIONS. The actuarial certification specified in sub. (6) shall be signed by an actuary who satisfies the requirements of s. Ins 6.12.

History: Cr. Register, April, 1988, No. 388, eff. 5-1-88; correction in (1) made under s. 13.93 (2m) (b) 7., Stats., Register October 2002 No. 562.

Subchapter II — Employee Benefit Plan Administrators

Ins 8.20 Purpose. This subchapter interprets and implements ch. 633, Stats.

History: Cr. Register, April, 1992, No. 436, eff. 5-1-92.

Ins 8.22 Definitions. In this subchapter:

(1) "Administrator" has the meaning given in s. 633.01 (1), Stats.

(2) "Commissioner" means the commissioner of insurance.

(3) "Employee" has the meaning given in s. 633.01 (2), Stats.

(4) "Office" means the office of the commissioner.

(5) "Plan" has the meaning given in s. 633.01 (4), Stats.

(6) "Principal" has the meaning given in s. 633.01 (5), Stats.

History: Cr. Register, April, 1992, No. 436, eff. 5-1-92.

Ins 8.24 Exemptions. (1) Each of the following is exempt from ch. 633, Stats., and this subchapter for the portion of its business subject to regulation under the specified sections:

(a) An administrator of one or more self-insured, partially insured or divided insurance worker's compensation plans subject to s. DWD 80.60 or 80.61.

(b) A warrantor or warranty plan administrator, as defined in s. Ins 15.01 (4) (c) or (e), that holds a valid certificate of authority under ch. Ins 15.

(2) An administrator that is partially exempt under sub. (1) (a) or (b) is subject to ch. 633, Stats., and this subchapter for any portion of its business that is outside the scope of the exemption.

History: Cr. Register, April, 1992, No. 436, eff. 5-1-92; correction in (1) (a) made under s. 13.93 (2m) (b) 7., Stats., Register, June, 1997, No. 498.

Ins 8.26 Licensing. (1) APPLICATION. A person applying for a new or renewal license as an administrator shall submit an application to the office in the form prescribed by the office. With the application, the person shall submit all of the following:

(a) With the initial application, a performance bond meeting the requirements of s. Ins 8.28.

(b) With a renewal application, proof that the bond continues to meet the requirements of s. Ins 8.28, if the amount required for the bond has changed.

(c) A financial statement for the administrator's most recently completed fiscal year, prepared according to generally accepted accounting principles. The financial statement shall report the administrator's assets, liabilities and net worth, the results of operations and the changes in net worth for the fiscal year on the accrual basis.

(d) A statement as to whether the administrator does any of the following:

1. Collects premiums or employee contributions on behalf of any principal.
2. Maintains separate fiduciary accounts for each principal.

(e) All of the following information about the administrator, if an individual, or about each officer, director, partner or other individual having comparable responsibilities in the organization, if a corporation or partnership:

1. Whether the individual has been fined or reprimanded or has been the subject of a consent decree in any state by any agency that regulates the business of administrators, insurance, real estate, securities or financial institutions.
2. Whether the individual has had a license to solicit insurance, real estate or securities or to act as an administrator refused, suspended, denied or revoked in any state.
3. Whether the individual has been convicted of a felony or misdemeanor, other than a misdemeanor related to the use of a motor vehicle or the violation of a fish and game regulation.
4. If the individual has ever been employed by an administrator or insurance company, or in the business of real estate, securities or financial institutions, whether his or her employment has been terminated or nonrenewed because of allegations of misconduct or wrongdoing.

(f) If the administrator is an individual, his or her insurance intermediary agent's license number and social security number and a statement that he or she intends to act as an administrator in good faith and in compliance with all applicable laws of this state and rules and orders of the commissioner.

(g) If the administrator is a corporation or partnership, its federal identification number, the state and year of its incorporation or year of its formation and a statement that it intends to act as an administrator in good faith and in compliance with all applicable laws of this state and rules and orders of the commissioner and that it has designated or will designate an individual with direct responsibility for each plan it administers.

(h) If the administrator is an individual who is not a resident of this state or a corporation or partnership that is not organized under the laws of this state, a statement that the administrator agrees to be subject to the jurisdiction of the commissioner and the courts of this state with respect to all matters pertaining to activities as an administrator and to accept service of process as provided under ss. 601.72 and 601.73, Stats.

(i) Any other information requested by the office.

(j) The fee specified under s. 601.31 (1) (w), Stats., which shall be nonrefundable.

(2) RENEWAL APPLICATION DEADLINE. An administrator shall submit a renewal application on or before August 1 of each year.

(3) APPLICATION REVIEW. The office shall review and approve or disapprove each complete application within 60 days after its receipt.

Note: The application form, which includes a sample performance bond format, OCI 30-001, may be obtained from the Office of the Commissioner of Insurance, P.O. Box 7872, Madison, Wisconsin 53707-7872.

History: Cr. Register, April, 1992, No. 436, eff. 5-1-92.

Ins 8.28 Performance bond requirements. (1) A performance bond required under s. 633.14 (1) (b) or (2) (b), Stats.,

shall be continuous in form, shall be issued by an insurer authorized to do a surety business in this state and shall be in favor of the commissioner and payable to any resident of this state who is the beneficiary of an employee benefit plan administered by the administrator and to any such employee benefit plan on behalf of the residents of this state who are its beneficiaries in the event of injury caused by a failure of the administrator to fulfill its responsibilities as an administrator.

(2) If the administrator collects premiums or employee contributions on behalf of any principal, or commingles funds belonging to more than one principal, the performance bond shall be in the greater of the following amounts:

(a) \$25,000.

(b) Ten percent of the total amount of projected premiums, charges and claim funds the administrator expects to handle on behalf of residents of this state during the fiscal year following the year for which a financial statement is submitted under s. Ins 8.26 (1) (c). A bond under this paragraph need not exceed \$500,000.

(3) If the administrator does not collect premiums or employee contributions on behalf of any principal, and maintains a separate fiduciary account for each principal, the performance bond shall be in the greater of the following amounts:

(a) \$15,000.

(b) Five percent of the total amount of projected claim funds the administrator expects to handle on behalf of residents of this state during the fiscal year following the year for which a financial statement is submitted under s. Ins 8.26 (1) (c). A bond under this paragraph need not exceed \$250,000.

(4) An administrator may exclude from the calculations required under sub. (2) (b) or (3) (b) all amounts handled as administrator for any of the following:

(a) Self-insured, partially insured or divided insurance worker's compensation plans subject to s. DWD 80.60 or 80.61.

(b) Warranty plans subject to ch. Ins 15.

History: Cr. Register, April, 1992, No. 436, eff. 5-1-92; correction in (4) (a) made under s. 13.93 (2m) (b) 7., Stats., Register, June, 1997, No. 498.

Ins 8.30 Notification to office. An administrator shall notify the office in writing of any of the following within 30 days after the date of the occurrence:

(1) The cessation of business activities as an administrator. A notification under this subsection shall include the name and address of the custodian of the administrator's business records and the location of those records.

(2) Any change in the administrator's business mailing address or the location of its business records.

(3) Formal administrative action in this state or another state by an agency that regulates the business of administrators, insurance, real estate, securities or financial institutions against the administrator or any officer, director, partner or other individual having comparable responsibilities in the corporation or partnership.

(4) The conviction in this state or another state of a felony or misdemeanor, other than a misdemeanor related to the use of a motor vehicle or the violation of a fish and game regulation, of the administrator or any of the officers, directors, partners or other persons having comparable responsibilities in the corporation or partnership.

History: Cr. Register, April, 1992, No. 436, eff. 5-1-92.

Ins 8.32 Audit. In order to determine whether the financial resources of an administrator are adequate to safeguard the interests of the public and persons covered by a plan, or to determine the appropriate bond amount under s. Ins 8.28, the office may order the administrator to submit financial statements that have been audited by a certified public accountant.

History: Cr. Register, April, 1992, No. 436, eff. 5-1-92.

Subchapter III — Small Employer Health Insurance

Ins 8.40 Purpose. This subchapter interprets and implements ch. 635, Stats., and s. 149.12 (2) (e), Stats.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92; am. Register, November, 1993, No. 455, eff. 2-1-94; correction made under s. 13.93 (2m) (b) 7., Stats., Register October 2002 No. 562.

Ins 8.42 Definitions. In addition to the definitions in s. 635.02, Stats., which apply to this subchapter, in this subchapter:

(1) “Basic market share ratio” means the ratio of the number of risk characteristic basic health benefit plans in force to the total number of basic health benefit plans in force.

(2) “Commissioner” means the commissioner of insurance.

(3) “Initial enrollment period” means a period prior to issuance of a policy during which eligible employees, and dependents of eligible employees, are entitled to enroll in coverage under the policy.

(4) “Late enrollee” means an eligible employee, or dependent of an eligible employee, who does not request coverage under a policy during an enrollment period in which the individual is entitled to enroll in the policy, and who subsequently requests coverage under the policy, regardless of whether the enrollment period was held prior to, on or after the law’s effective date. “Late enrollee” does not include an individual who:

(a) Did not request coverage during an enrollment period under a basic health benefit plan, is covered under the plan established under ch. 149, Stats., under s. 149.12 (2) (e), Stats., and has not terminated eligibility for coverage under the plan established under ch. 149, Stats.; or

(b) Did not request coverage during an enrollment period for a policy other than a basic health benefit plan which commenced prior to February 1, 1994, and who was covered during the enrollment period under the plan established under ch. 149, Stats.; or

(c) Is a new entrant under sub. (7) (b) or (c).

(5) “Law’s effective date” means May 12, 1992, or the first renewal date of a policy which occurs on or after May 12, 1992, whichever is later.

(6) “Market share ratio” means the ratio of the number of risk characteristic basic health benefit plans in force to the total number of policies in force.

(7) “New entrant” means an eligible employee, or the dependent of an eligible employee, who:

(a) Becomes part of an employer group on or after the law’s effective date and after commencement of an initial enrollment period;

(b) Is a spouse, minor or dependent under a covered employee’s policy who a court orders be covered under the policy and who requests enrollment within 30 days after issuance of the court order; or

(c) Failed to request enrollment in the policy during an enrollment period which commenced prior to, on or after the law’s effective date, during which the individual was entitled to enroll in the policy, if the individual:

1. Is covered under qualifying coverage during the enrollment period and the qualifying coverage is not the plan established under ch. 149, Stats., or, if it is the plan established under ch. 149, Stats., it is obtained under s. 149.12 (2) (e), Stats.;

2. Subsequently, and on or after February 1, 1994, loses coverage under the qualifying coverage; and

3. Requests enrollment within 30 days after termination of the qualifying coverage.

(8) “Office” means the office of the commissioner.

(9) “Policy” means any of the following:

(a) A group health benefit plan issued to a small employer.

(b) An individual health benefit plan, including, but not limited to, an individual health benefit plan which is intended or designed to supplement a basic health benefit plan, issued by an insurer to an eligible employee if 3 or more eligible employees of the same small employer apply for the coverage or were intentionally excluded from applying for reasons related to their health, and the individual health benefit plan is in fact, or in substance, sold to, or through active cooperation of, the small employer, including but not limited to circumstances where:

1. Premium is collected through a direct or indirect arrangement with the small employer;

2. The individual health benefit plan is in substance a replacement for group health benefit plan coverage provided through the small employer;

3. The small employer directly or indirectly contributes toward a portion of the premium for the individual health benefit plan; or

4. An eligible employee is solicited to purchase the individual health benefit plan on the premises of the small employer and with the consent and cooperation of the small employer or the small employer participates in the solicitation of the eligible employee.

(c) For a health benefit plan that provides coverage through a trust or association, a certificate or other evidence of coverage, including, but not limited to, coverage intended or designed to supplement a basic health benefit plan, issued to an individual small employer or in fact or substance, sold to, or through the active cooperation of, the small employer, including but not limited to circumstances where:

1. Premium is collected through a direct or indirect arrangement with the small employer;

2. The coverage is in substance a replacement for group health benefit plan coverage provided through the small employer;

3. The small employer directly or indirectly contributes toward a portion of the premium for the coverage; or

4. An eligible employee is solicited to purchase the coverage on the premises of the small employer and with the consent and cooperation of the small employer or the small employer participates in the solicitation of the eligible employee.

(d) A group health benefit plan which supplements or is designed to supplement the basic health benefit plan.

(10) “Risk characteristic” means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of a small employer group or of any member of a small employer group.

(11) “Risk characteristic basic health benefit plan” means a basic health benefit plan which, when issued, is issued to a small employer group which:

(a) Is not eligible for any policy available from the small employer insurer, other than the basic health benefit plan or health benefit plans that do not provide benefits similar to or exceeding benefits provided under the basic health benefit plan as determined under s. Ins 8.66 (1), under the underwriting standards of the small employer insurer and based on the small employer group’s risk characteristics; or

(b) Is assigned a rate for the basic health benefit plan which exceeds the new business premium rate for the basic health benefit plan by 15% or more.

(12) “Risk load” means the percentage above the applicable base premium rate that is charged by a small employer insurer to a small employer to reflect the risk characteristics of the small employer group.

(13) “Underwritten individual” means an individual who, prior to the law’s effective date, requested but was excluded from coverage, or denied coverage, under a policy, whether issued by the current insurer or a preceding insurer, and continued to be and

is an eligible employee, or dependent of an eligible employee, of the small employer. "Underwritten individual" does not include a person who is covered under the plan established under ch. 149, Stats., on February 1, 1994.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92; renum. (1) to (3) to be (2), (8) and (9) and am. (9) (b) and (c), cr. (1), (3) to (7), (9) (d), (10) to (13), Register, November, 1993, No. 455, eff. 2-1-94; corrections in (4) (a), (b), (7) (c) 1. and (13) made under s. 13.93 (2m) (b) 7., Stats., Register October 2002 No. 562.

Ins 8.44 Applicability; exclusion. (1) Chapter 635, Stats., and this subchapter apply to a policy issued to, or renewal for, an employer if the number of eligible employees in this state was not less than 2 nor more than 25 during at least 50% of the number of weeks the employer was actively engaged in the business enterprise during the 12 months preceding the date of application or the policy renewal date.

(2) A small employer insurer shall notify each employer in writing when a policy is issued that if the employer employs less than 2 or more than 25 eligible employees during at least 50% of the number of weeks in any 12-month period, or moves the business enterprise outside this state, the protections provided under ch. 635, Stats., and this subchapter will cease to apply to the employer on renewal of its health benefit plan.

(3) In addition to the types of policies excluded under ch. 635, Stats., and this subchapter do not apply to policies providing only specified disease coverage or to hospital indemnity policies, as defined in s. 632.895 (1) (c), Stats.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92; am. (1), renum. (2) to be (3), cr. (2), Register, November, 1993, No. 455, eff. 2-1-94; corrections in (intro.), (2) and (3) made under 13.93 (2m) (b) 7., Register, March, 2000, No. 531.

Ins 8.46 Required policy provisions. Each policy shall include all of the following:

(1) On the face page or first page, a statement that the policy is guaranteed renewable except for the reasons stated in the policy, which shall be consistent with s. 635.07 (1) and (2), Stats.

Note: 1995 Wis. Act 289 repealed s. 635.07, Stats. See ss. 632.749 (2) and 635.19 (3), Stats.

(2) A statement of the minimum number of eligible employees required in order to keep the policy in effect, expressed either as a schedule or as a percentage of eligible employees or both. The small employer insurer shall state the method for determining the minimum number required in the policy or employer agreement. For purposes of this subsection, "eligible employee" does not include any person who has continued coverage under s. 632.897 (2) (b) 2., Stats., under a small employer's group policy and the number of individuals in a group shall not include individuals with other qualifying coverage except as permitted under s. 635.17 (2) (c) 2., Stats. A small employer insurer may not impose more stringent requirements than the following:

Note: 1995 Wis. Act 289 repealed s. 635.17, Stats. See s. 632.749 (2), Stats.

(a) For a small employer with more than 10 eligible employees, 70% of the group.

(b) For a small employer with 10 eligible employees, 6 eligible employees.

(c) For a small employer with 8 or 9 eligible employees, 5 eligible employees.

(d) For a small employer with 7 eligible employees, 4 eligible employees.

(e) For a small employer with 5 or 6 eligible employees, 3 eligible employees.

(f) For a small employer with 2 to 4 eligible employees, 2 eligible employees.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92; am. (2), Register, November, 1993, No. 455, eff. 2-1-94.

Ins 8.48 Solicitation; disclosure requirements.

(1) AGENTS. Before completing an application for a policy, an agent shall provide the small employer or representative of the small employer or the individual applicant with a form stating the information required under s. 635.11 (1m), Stats. The agent shall

sign and date the form certifying that he or she made the required disclosure and shall obtain the signature of the small employer or representative of the small employer or the individual applicant on the form. The agent shall give one copy of the completed form to the person who signed it. The agent or small employer insurer shall retain one copy of the completed form.

(2) SMALL EMPLOYER INSURERS. A small employer insurer that does not use agents to solicit or sell policies shall, with any solicitation material, provide the small employer or individual applicant with a form stating the information required under s. 635.11 (1m), Stats. The small employer insurer shall secure with or as part of each application a form signed by the small employer, a representative of the small employer or individual applicant stating that he or she has received the information. The small employer insurer shall provide a copy to the person who signed the form no later than the date the policy is issued.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92; corrections made under s. 13.93 (2m) (b) 7., Stats., Register October 2002 No. 562.

Ins 8.49 Uniform employee application form. (1) (a) In accordance with s. 635.10, Stats., small employer insurers shall use the small employer uniform employee application form as the only acceptable form when small employers apply for coverage from small employer insurers. Small employer insurers shall implement procedures and policies necessary to use the small employer uniform employee application form.

(b) Small employer insurers shall treat and accept a copy of the uniform employee application as an original.

(c) The contents of the uniform small employer application shall not vary, except as permitted in par. (d), from the text or format including bold character, line spacing, the use of boxes around text and shall use a type size of at least 10 points as delineated in form OCI 26-501.

(d) Small employer insurers and licensed intermediaries may pre-print the name of the small employer insurer on the uniform employee application provided that the form contains at least 3 additional spaces to insert the names of insurers to whom the uniform applications may be sent and the form complies with par. (c).

Note: A copy of the uniform employee application form OCI 26-501 (c. 2/2004), required in par. (a), may be obtained at no cost from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison WI 53707-7873, or at the Office's web address: oci.wi.gov.

(2) (a) The information contained within each uniform employee application shall be considered current information by the small employer insurer if the information is received by the small employer insurer within 45 days of completion of the earliest signed and completed uniform employee application form. For the period of time that the information contained within the uniform employee application is considered current, small employer insurers may not require a small employer employee to complete a new application form or any document, addendum or certification representing that the information contained in the completed uniform employee applications is current.

(b) A small employer insurer may accept and utilize information provided by a small employer employee subsequent to the date the employee signed the completed application if the employee is providing the insurer with additional or modified information.

(c) A small employer insurer may require small employer employees to complete and submit new uniform employee applications if either of the following occurs:

1. The authorization signed by the employees does not include the name of the small employer insurer that the small employer is requesting provide it with an underwritten premium amount and coverage.

2. The completed uniform employee applications are received by the small employer insurer after 45 days of completion of the earliest signed and completed uniform employee application.

(3) (a) Small employer insurers that receive a written request from a small employer to forward copies of the completed uniform employee applications to a different small employer insurer listed within the authorization section of the application shall forward copies of the uniform employee applications within 5 business days from receipt of the request without requiring a fee be paid for the photocopying or delivery of the copies of completed uniform employee applications. The small employer insurer shall notify the employer, as soon as practicable, if the small employer insurer is unable to comply with the request because the small employer has requested that information be sent to a small employer insurer not identified within the authorization.

(b) An intermediary shall forward, within 5 business days from receipt of the applications, copies of the uniform employee applications to all small employer insurers identified within the uniform employee application authorization to receive the applications, or to an authorized representative of each small employer

insurer. The intermediary may withhold distribution to a small employer insurer, or the insurer's authorized representative, at the request of the small employer.

(c) Completed uniform employee applications shall be maintained by small employer insurers and licensed intermediaries, as applicable, in accordance with subch. V of ch. Ins 25.

(4) (a) Small employer insurers shall either state the premium to the small employer within 10 business days from receipt of all pertinent information required for its underwriting of the small employer's application for group health insurance, including completed uniform employee applications, or deny the application in accordance with s. 635.18 (6), Stats.

(b) Small employer insurers shall make a reasonable effort to promptly obtain information it determines is necessary to make an underwriting decision including the information described in par. (a).

History: CR 03-055: cr. Register April 2004 No. 580, eff. 5-1-04.

APPENDIX 1

Employee Name _____

**SMALL EMPLOYER UNIFORM
EMPLOYEE APPLICATION FOR GROUP
HEALTH INSURANCE**



State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-3585
Web Address: oci.wi.gov

Ref: Section Ins 8.49, Wis. Adm. Code, and
Sections 601.41 (8), 635.10, Wis. Stat.

This form is designed for an employer's initial application for coverage. Please contact your agent or the insurer to determine if this form should be used in other situations once the group is enrolled with the insurer.

EMPLOYER INFORMATION – To be filled out by Employer

Employer Name _____ Group Number _____ Division Number _____
Employee Class _____
Total number of permanent employees who have a normal work week of 30 or more hours _____
Names of Insurers to whom information may be released:
Insurer: _____ Insurer: _____
Insurer: _____ Insurer: _____

I. EMPLOYEE INFORMATION

Employee Instructions: Please print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought.

Employee's First Name, Middle Initial and Last Name: _____
Social Security No.: _____ Birth Date: _____ Sex: _____ Height and Weight: _____
Street or Post Office Address: _____
City: _____ County: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Email: _____ [] Home [] Work
1. For your current employer: What was your first day of employment? ____/____/____
How many hours, on average, do you work each week? _____
2. Are You:
a) [] Single [] Married [] Legally Separated [] Divorced [] Widow or Widower
If you are married, legally separated, divorced or widowed, please indicate the date that the event occurred: _____
If you are married, please indicate the county and state, or country in which you were married: _____
If you are married, please indicate your former or maiden name: _____
b) A Retiree? [] Yes [] No
c) On COBRA or State Continuation? [] Yes [] No
If "Yes," provide start date and reason: _____

II. TYPE OF HEALTH COVERAGE

Please select the type of health insurance coverage for which you are applying:
[] Employee Only [] Employee and Spouse [] Employee and Dependent Child(ren) [] Employee, Spouse and Dependent Child(ren)

III. DEPENDENT INFORMATION

a) List all dependents, spouse and child(ren) applying for insurance. If you need additional space, please use a separate sheet of paper and attach it to this application (**please sign and date the additional sheet**).

Name (First; M.I.; Last)	Sex	Social Security Number	Relationship	Birth Date (Mo/Day/Yr)	Height Weight
			Spouse		
			[] Child [] Stepchild [] Grandchild [] Other _____		
			[] Child [] Stepchild [] Grandchild [] Other _____		

- b) Does the dependent child(ren) named within this application live with you at the address shown above? Yes No
 If "No," please list the dependent child(ren)'s name and address(es):

- c) If there is a stipulation in a legal decree or court order stating who is responsible for providing health insurance of the named dependent child(ren), please indicate name of the person who has primary custody of the dependent child(ren) and the name of the responsible person for health insurance:

IV. MEDICAL INFORMATION

Please answer the following questions to the best of your knowledge. On the next page, please provide the complete details if you answer "Yes" to any of the questions below. The date that this application is signed is the date that you should use when answering questions that request you to provide prior history for various periods of time. The health insurance company does not use or collect genetic information for any underwriting purpose. Genetic information includes information related to genetic tests, genetic counseling, and any family history of a disease or disorder. Any such information should not be included on an application or communicated to the insurance company in any manner. Any genetic information that may be obtained will not be used for underwriting of health coverage. **You are required to promptly notify your employer so that you may provide updated information to the small employer insurer(s) of any changes or developments in your, your spouse's or your dependent child(ren)'s health history that occur prior to your employer's notifying you that there has been an insurer's underwriting decision regarding this application.**

- A. Are you, your spouse or any dependent child(ren) (even if not listed on the application) currently pregnant or an expectant parent? (If "Yes," due date is _____) Yes No
- B. Has anyone named in this application been treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
- C. Has anyone named in this application used tobacco or smokeless tobacco during the past 12 months? Yes No
 If "Yes," provide information as requested regarding the product, duration and frequency of use in section H below.
- D. In the past 5 years has anyone named in this application been evaluated or treated for alcoholism or chemical dependency; or joined any organization for alcoholism or chemical dependency; or used illegal drugs or been advised by a health care professional to reduce the use of alcohol or illegal drugs? Yes No
- E. Is anyone named in this application now disabled, mentally incompetent or unable to perform normal work or age-related activities? Yes No
 If "Yes," please identify name(s), health condition(s), date(s) of disability and name(s) and address(es) of the attending physician(s):

- F. Within the past 10 years, has anyone named in this application been counseled, consulted or treated for any of the following (please check all conditions that apply):

1. CIRCULATORY SYSTEM

- a) heart disease or disorder Yes No
- b) stroke Yes No
- c) circulatory disorder Yes No
- d) chest pain Yes No
- e) high or low blood pressure Yes No
- f) elevated cholesterol and/or triglyceride levels Yes No
- g) anemia or blood disorder Yes No

2. DIGESTIVE SYSTEM

- a) ulcers Yes No
- b) stomach disorder Yes No
- c) liver/pancreas disorder Yes No
- d) gallbladder disorder Yes No
- e) intestinal disorder (e.g., colitis, Crohn's disease) Yes No
- f) hernia Yes No
- g) rectal disorder Yes No

3. GENITOURINARY SYSTEM

- a) menstrual disorder Yes No
- b) genital disorder Yes No
- c) sexual dysfunction Yes No

- d) pregnancy complications (e.g., premature birth, miscarriage, c-section) Yes No

- e) infertility Yes No
- f) urinary tract/kidney/bladder disorder Yes No
- g) prostate disorder Yes No

4. ENDOCRINE SYSTEM

- a) diabetes Yes No
- b) thyroid disorder Yes No
- c) adrenal disorder Yes No
- d) enlargement of the lymph-nodes Yes No
- e) connective tissue disorder Yes No

5. RESPIRATORY SYSTEM

- a) allergy(ies) Yes No
- b) asthma Yes No
- c) emphysema Yes No
- d) sinus or nasal disorder Yes No
- e) lung disease or disorder Yes No
- f) shortness of breath Yes No

6. MUSCULAR or SKELETAL

- a) arthritis Yes No
- b) fibromyalgia Yes No
- c) back disorder Yes No

- d) joint disorder Yes No
- e) musculoskeletal disorder Yes No
- f) skin disorder Yes No
- g) chronic fatigue syndrome Yes No
- 7. NERVOUS SYSTEM**
- a) epilepsy or other seizures Yes No
- b) headaches Yes No
- c) multiple sclerosis Yes No
- 8. CANCER**
- a) cancer Yes No
- b) tumor Yes No
- c) abnormal growth Yes No
- d) carcinoma in situ Yes No

- 9. EAR OR EYE**
- a) eye disorder Yes No
- b) ear disorder Yes No
- 10. BEHAVIORAL HEALTH**
- a) attention deficit disorder Yes No
- b) psychological disorder Yes No
- c) suicide attempt Yes No
- d) eating disorder Yes No
- 11. OTHER**
- a) organ or other type of transplant or implant Yes No
- b) breast disorder Yes No
- c) lupus Yes No

G. Within the last 5 years, has anyone named in this application to be covered by this insurance had any other injury, illness or treatment for any condition not already listed; been hospitalized or been scheduled for hospitalization; had surgery or had surgery scheduled; had a test or a test scheduled; or been recommended to have a test or surgery which was not performed for any reason not already mentioned in this application? *We are not seeking the results of HIV Antibody test.* Yes No

H. In the space below please list and provide the complete details if you answered "Yes" above to any of the questions or conditions contained in sections A through F. (Attach additional pages as needed and sign the additional pages.)

Question Number	Name of Person	Date(s) of Treatment	Give full details for each question answered "Yes," state the condition, duration and degree of recovery.	Name and address of attending physician or other health care provider.

I. If anyone named in this application is taking medication or has had prescribed or recommended any medication during the period of time related to your answer (i.e. past 5 years, past 10 years, or currently taking), please list all those medications, dosages, and what medical condition is being treated or were treated by each medication in the space provided below. (Attach additional pages as needed and sign the additional pages.)

Name of Person	Name, dosage and frequency of medication (include illness or health condition for which medication was prescribed)	Date(s) medication taken (indicate if ongoing)	Name and address of prescribing physician or licensed health care provider and dispensing pharmacy

V. WAIVER OF COVERAGE

I understand that I am eligible to apply for group health insurance through my employer. I do **NOT** want, and hereby waive, group health insurance for (check the box that applies):

- Waiving for myself Waiving for my spouse Waiving for my dependent child(ren)
- Waiving for me, my spouse and my dependent child(ren)

I am **waiving** group health insurance because (check all that apply):

- I, the employee, am covered or will be covered under another plan that is not sponsored by my employer. I am **not** enrolled for coverage under the Health Insurance Risk-Sharing Plan (HIRSP). If currently covered, please attach a copy of your identification card for that plan.
- I, the employee, do not have a risk characteristic or other attribute that would be the sole cause for the small employer insurer to make a decision with respect to premiums or eligibility for a policy that is adverse to the small employer.
- My spouse is covered or will be covered under another plan that is not sponsored by this employer. My spouse is **not** enrolled for coverage under the Health Insurance Risk-Sharing Plan (HIRSP). If currently covered, please attach a copy of your spouse's identification card for that plan.
- My dependent child(ren) is covered or will be covered under another plan that is not sponsored by my employer. My dependent child(ren) is **not** enrolled for coverage under the Health Insurance Risk Sharing Plan (HIRSP). If currently covered, please attach your identification card for that plan. Please list, below, the name(s) of the child(ren) for whom coverage is being waived.
- I am **not** enrolled under the Health Insurance Risk-Sharing Plan (HIRSP) and the annualized premium contribution to be paid by me on behalf of myself or my dependent spouse and child(ren) would exceed **10%** of my **annualized gross earnings from this employer**.
- Other reason (Please provide a written reason for waiving coverage):

WAIVER: I certify that I have been given the opportunity to apply for group health insurance and decline to enroll as indicated above, on behalf of myself, my spouse and my dependent child(ren). I understand that by signing this waiver, I, my spouse, and my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the insurer(s) into

waiving or declining the group health insurance. If in the future I apply for coverage, I, my spouse, or any of my dependent child(ren) may be treated as a late enrollee and subject to postponement or an exclusion of coverage for preexisting conditions for a period of up to 18 months. This period may be offset by the time I, my spouse or my dependent child(ren) was covered under a qualified health plan.

I understand that if I am declining enrollment for myself, my spouse, or my dependent child(ren) because of other health insurance coverage, including Medicaid, I may in the future be able to enroll myself, my spouse, or my dependent child(ren) in this plan, provided that I request enrollment within 30 days after my other health coverage ends or 60 days after Medicaid ends. In addition, if I gain a dependent spouse or child(ren) as a result of marriage, birth, adoption, or placement for adoption, I understand that I may be able to enroll myself, my spouse and my dependent child(ren), provided that I request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. If I am declining enrollment for myself, my spouse or my dependent child(ren) because of coverage under Medicaid, I understand that if I, my spouse or my dependent child(ren) become eligible for group health plan premium assistance under Medicaid, I may be able to enroll myself, my spouse or my dependent child(ren), provided I request enrollment within 60 days of initial eligibility for the premium assistance. I understand that I can obtain enrollment information from my employer or small employer group health insurance carrier.

Signature of Employee: _____ Date Signed: _____

VI. MEDICARE INFORMATION

If you need to complete this section for more than one person, **please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet).**

Are you, your spouse or your child(ren) covered by Medicare Part A? Yes No Medicare Part B? Yes No
 Medicare Part D Yes No

Name of person covered by Medicare: _____

If "Yes," reason for Medicare: Over Age 65 Disability End-Stage Renal Disease (ESRD) Disability and ESRD

Medicare Part A Effective Date: _____ Medicare Part B Effective Date _____

Medicare Part C (Medicare Advantage) Effective Date: _____ Medicare Part D Effective Date: _____

VII. CURRENT AND PREVIOUS COVERAGE

The information you provide about your other individual or group health insurance coverage (either prior or current) is necessary to determine whether you will have any waiting periods for preexisting conditions under the group health insurance plan under which you are applying for coverage. Your information will also help the small employer insurer(s) to coordinate benefits with any other group health coverage you may have. By providing this information you are not reducing your group health insurance for which you are applying.

Do you, your spouse or your dependent child(ren) listed in this application have current health insurance coverage or had previous health insurance coverage within the last 18 months? Yes No

If "Yes," please complete the following table and attach a copy of the Certificates of Creditable Coverage for each person.

Starting with you, the employee, identify each person applying for insurance and include information for all current and previous health insurance coverage(s) in effect during the last 18 months.

Name	Insurance Company, Plan & Group Number	Effective Date of Coverage (mo/day/yr)	Termination Date of Coverage (mo/day/yr)	Reason for Termination of Coverage	Type of Coverage (see key below)

Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; M = Medicare Supplement; D = Drug Coverage Only; H = Hospital Coverage Only; V = Vision Coverage Only

VIII. HEALTH PROVIDER OR PRODUCT SELECTION, IF APPLICABLE

This section should be completed only if the small employer group insurance for which you are applying requires the selection of a network, primary care provider or clinic. If applicable, it should also be used to select the product options offered by the employer or insurer. With respect to the provider or network selection, a selection should be made for each individual applying for such coverage and for each insurer from which insurance coverage is being sought. The provider numbers may be listed in the provider materials (i.e., directory) that are supplied by each insurer to your employer. The provider numbers for the same provider may not be the same for different insurers or products. **Use additional sheets if necessary.**

Insurer: _____

Product Type: _____

Coinsurance Option: _____ Deductible Option: _____ Copayment Option: _____

Selected Provider is for (choose only one): Health Insurance Dental Insurance Other _____

Covered Person's Name	Network or Provider's Name or Number	Is this your current provider?

Insurer: _____

Product Type: _____

Coinurance Option: _____ Deductible Option: _____ Copayment Option: _____

Selected Provider is for (choose only one): Health Insurance Dental Insurance Other _____

Covered Person's Name	Network or Provider's Name or Number	Is this your current provider?

IX. NON-HEALTH INSURANCE COVERAGE SELECTION, IF APPLICABLE

Availability of coverage is determined by your employer and whether the coverage is approved for issuance by the insurer(s).

Please list the insurer(s) below from whom you are applying for coverage and check all benefits for which you are applying.

If you have been given a choice of plans to apply for, or if the coverage you are applying for requires the selection of a primary care provider/clinic/network, please complete the section entitled "Provider and/or Product Selection."

If you are waiving application for any coverage on yourself and/or your spouse and/or dependent child(ren), please complete the "Waiver of Coverage" section at the end of this section.

A. GROUP DENTAL COVERAGE

- Employee Employee and Spouse Employee and Dependent Child(ren)
 Employee, Spouse and Dependent Child(ren)

Insurer: _____ Insurer: _____

Insurer: _____ Insurer: _____

Within the past 12 months, have you, your spouse or your dependent child(ren) had any individual or other group dental coverage?
 Yes No

If "Yes," please provide the following information:

Orthodontia coverage? Yes No

Dental Insurer Name: _____ Policy Number: _____

Address: _____ Phone Number: _____

Coverage Effective Date: _____ Termination Date: _____

Is coverage still in effect? Yes No

Who was or is covered under the policy listed above? _____

Please attach copies of Certificates of Prior Coverage.

B. GROUP LIFE/AD&D COVERAGE (dependent coverage only available if employee coverage elected)

Insurer: _____ Insurer: _____

Insurer: _____ Insurer: _____

Employee Life/AD&D Amounts: Basic Issue \$ _____ Supplemental \$ _____ Optional \$ _____

Primary Beneficiary Name _____ Beneficiary's Social Security _____

Relationship of Beneficiary _____

Secondary Beneficiary Name _____ Beneficiary's Social Security _____

Relationship of Beneficiary _____

Dependent Life Amounts: Basic Issue \$ _____ Supplemental \$ _____ Optional \$ _____

- Dependent Spouse Only Dependent Child(ren) Only Dependent Spouse and Dependent Child(ren)

C. GROUP DISABILITY COVERAGE (only available to employees)

- Short Term Disability Long Term Disability Your Annual Salary \$ _____

Insurer: _____ Insurer: _____

Insurer: _____ Insurer: _____

Basic Benefit Amount \$ _____ / per week Optional Benefit Amount \$ _____ / per week

D. GROUP DRUG COVERAGE

- Employee Employee and Spouse Employee and Dependent Child(ren)

- Employee, Spouse and Dependent Child(ren)

Insurer: _____ Insurer: _____

Insurer: _____ Insurer: _____

E. GROUP VISION COVERAGE

- Employee Employee and Spouse Employee and Dependent Child(ren)

- Employee, Spouse and Dependent Child(ren)

Insurer: _____ Insurer: _____

Insurer: _____ Insurer: _____

F. WAIVER OF NON-HEALTH COVERAGE – This section must be completed if you or your dependents do NOT want the coverage listed above that is available to you through your employer.

I understand that I am eligible to apply for coverage through my employer. I do NOT want coverage for (check all that apply):

Employee: Dental Basic Life/AD&D Supplemental Life/AD&D Optional Life
 Basic Disability Optional Disability Drug Vision

Spouse: Dental Basic Life Supplemental Life Optional Life Drug Vision

Dependent Child(ren): Dental Basic Life Supplemental Life Optional Life Drug Vision

The reason I am waiving group coverage at this time is because of:

Spousal coverage Individual Coverage Medicare Medical Assistance

Other: _____

WAIVER: I certify that I was not pressured, forced or unfairly induced by my employer, the agent, or the insurer(s) into waiving (declining) the above-noted coverage. I understand that in the event that I should decide to apply for such coverage at a later date, the application will be subject to the applicable terms and conditions of the employer’s policy(s), which may require additional limitations and waiting periods. I also understand that I, my spouse and my dependent child(ren) may be required to furnish, at my own expense, evidence of health status/health history representation satisfactory to the insurer(s). I understand that the insurer(s) reserves the right to deny coverage with any future application for coverage.

Signature of Employee: _____ Date Signed: _____
 Signature of Spouse: _____ Date Signed: _____

X. TERMS AND CONDITIONS

I hereby enroll for coverage under the insurance coverage(s) for which I am presently eligible, or for which I may become eligible under my employer’s group contract(s). I have indicated in this Wisconsin Uniform Employee Application for Small Employer Group Health Insurance, if required, the Provider or Product Selection. I understand and agree that the information obtained by using this Application will be used by the insurer(s) to determine eligibility for benefits under my employer’s group insurance policies. I, on behalf of myself, my spouse and my dependent child(ren), if any, named herein, agree to cooperate in providing the insurer(s) with information needed to process this Application. This might include signing a form for the release by hospitals, doctors, and other health care providers of pertinent health care records to the Medical Information Bureau, the insurer(s) or their legal representatives.

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified in the space provided below the person(s) who provided me with such assistance. I declare and agree that the answers are, to the best of my knowledge and belief, complete and true and, together with any supplements or addendums thereto, shall be the basis for any certificate of coverage or certificate of insurance issued. I understand and agree that neither the employer nor the agent has the authority to waive a complete answer to any question, pass on insurability, alter any contract, or waive any of the insurer’s other rights or requirements. I additionally agree that the insurer(s) is not liable for any statement, representation, or other information provided to me, my spouse or my dependent child(ren) that is not expressly contained in a written document provided by the insurer and signed by an authorized officer of the insurer. I agree that no insurance will be effective until the date specified by the company on the certificate of coverage or certificate of insurance after this application has been accepted. I understand that any misrepresentation contained herein and relied upon by the insurer may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of risk. I also understand that if I decline any coverage, future changes in coverage are NOT automatic and may be subject to the insurer’s approval.

I understand and acknowledge that any person who, with intent to defraud or knowledge that the person is facilitating a fraud against an insurer, submits an application or files a claim containing a false deceptive statement is committing a fraudulent act that is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of intentionally misleading an insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

If any payroll deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice to the employer. An Application should not be submitted more than 45 days prior to the effective date. This document will become a part of the insurance contract when coverage is approved and issued.

I understand that I may request a copy of this Application and the Authorization to Use and Disclose Protected Health Information that are part of this Application. I agree that a photographic copy shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original.

Signature of Employee: _____ **Date Signed:** _____

Signature of Spouse: _____ **Date Signed:** _____

Signature of each listed dependent who has attained the age of 18:

_____ **Date Signed:** _____ **Print Name** _____
 _____ **Date Signed:** _____ **Print Name** _____

Complete this section if someone assisted you in the completion of this Application.

The following person assisted me in completing the Application: _____

Please explain your relationship with the Applicant: _____

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Instructions: Please read this authorization form carefully before signing. This form must be signed by each adult person seeking coverage, including all adult dependent children. Parents should sign for their minor children unless the minor has received treatment without parental consent, consistent with state law. Your application cannot be processed without a signature for each person seeking coverage. Signing this form is a condition of coverage: if you decide not to sign, you will not be enrolled in a health plan of the insurers listed below. You have the right to receive a copy of this form following your signature.

I. Protected Health Information

By signing this form, I authorize certain organizations and persons to use or disclose my, my spouse's and my dependent child(ren)'s protected health information. Protected health information includes, but is not limited to, hospital records, physician records, lab results, mental health records, and alcohol and/or drug abuse records. Protected health information may be written, oral, or electronic. This form does not permit the use or disclosure of psychotherapy notes or the disclosure of information concerning whether I, my spouse or my dependent child(ren) have obtained a test for the presence of HIV antigen or nonantigenic products of HIV or an antibody to HIV or what the results of this test were.

II. Purpose of this Authorization Form

By signing this form, I, my spouse and my dependent child(ren) authorize the use and disclosure of protected health information for the purposes of pre-enrollment underwriting or risk-rating of health insurance coverage for me, my spouse and my dependent child(ren), to determine eligibility for enrollment or benefits under a health plan or to allow the insurer to conduct utilization review and quality improvement activities ("Purpose").

III. Entities Authorized to Use and Disclose My Protected Health Information

Insurers: I hereby authorize the following insurers, their reinsurers, and their legal representatives ("Insurers") to receive, use, and disclose my, my spouse's and my dependent child(ren)'s protected health information for the Purpose listed above:

Insurer: _____ Insurer: _____
 Insurer: _____ Insurer: _____

I authorize the Insurers to disclose my, my spouse's and my dependent child(ren)'s protected health information: between themselves, to reinsuring companies, and to the plan administrator (if other than the employer), plan sponsor (if other than the employer), insurance intermediaries, or other persons or organizations performing business or legal services in connection with the Purpose above.

I further authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc., consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me, my spouse or my dependent(s), to give to Insurers any and all protected health information about me, my spouse, or my dependent(s) to be covered concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal trait, and mode of living, including, but not limited to, all medical and health care records, but not including whether I, my spouse or my dependent(s) obtained a test for the presence of HIV antigen or nonantigenic products of HIV or what the results of this test were.

I, my spouse and my dependent child(ren) understand that protected health information described in this form may be used by, or disclosed to or by, organizations and persons who are not subject to federal or state privacy laws.

IV. Term of Authorization

I agree this Authorization shall be valid for two and one half (2 1/2) years from the latest signature date below.

V. Right to Revoke

I understand I, my spouse or my dependent child(ren) may revoke this authorization at any time by giving advance written notice to Insurers. Revocation of this authorization form will not affect actions Insurers and others took in reliance on this form prior to the written notice of revocation.

I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THIS FORM. I UNDERSTAND THAT, BY SIGNING THIS FORM, I AUTHORIZE THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION DESCRIBED IN THIS FORM. I UNDERSTAND THAT I MAY ONLY REVOKE AUTHORIZATION FOR MYSELF OR MY MINOR CHILD(REN) UNLESS MY MINOR CHILD(REN) HAS RECEIVED TREATMENT WITHOUT MY CONSENT, CONSISTENT WITH STATE LAW. (CONTINUED ON THE NEXT PAGE.)

Signature of Adult Applicant	Date signed	Printed Name
Signature of Spouse (if applicable)	Date signed	Printed Name

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (Continued)

I have had full opportunity to read and consider this form. I understand that, by signing this form, I authorize the uses and disclosures of protected health information described in this form. I understand that I may only revoke authorization for myself or my minor child(ren) UNLESS MY MINOR CHILD(REN) HAS RECEIVED TREATMENT WITHOUT MY CONSENT, CONSISTENT WITH STATE LAW.

Signature of Adult Dependent	Date signed	Printed Name
Signature of Parent or Legal Guardian for Minor Child(ren) (if applicable)	Date signed	Name of Minor Child (please print)

If signing for more than one child, please list the names of each child for whom you are signing:

Name of Minor Child (please print)	Name of Minor Child (please print)
Name of Minor Child (please print)	Name of Minor Child (please print)

For services received by a minor that under state law the minor may consent to treatment without parental or legal guardian consent:

Signature of Parent or Legal Guardian for Minor Child (if minor received treatment with knowledge of parent)	Date signed	Name of Minor Child (please print)
Signature of Minor Child (if minor may have received treatment that does not require parent or legal guardian authorization)	Date signed	Name of Minor Child (please print)
Signature of Minor Child (if minor may have received treatment that does not require parent or legal guardian authorization)	Date signed	Name of Minor Child (please print)

Ins 8.50 Underwriting restriction. In determining whether to issue or continue to provide coverage to a small employer, a small employer insurer may not consider the occupation of the employees of the small employer or the type of business in which the small employer is engaged.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92.

Ins 8.52 Regulation of rates and rate changes.

(1) IDENTIFICATION OF THE SET OF MIDPOINT RATES. (a) Each small employer insurer shall identify a set of rates applicable to all combinations of case characteristics and benefit design characteristics that serves as the set of midpoint rates for policies issued to small employers. These rates shall be represented by any combination of rates and rating factors that satisfy the following:

1. All differences among rates in the set shall be in accordance with the insurer's rate manual or rating procedures and shall be based on the actuarially determined values of the differences in case characteristics and benefit design characteristics.

2. The differences among the rates may not reflect any differences due to such factors as the claim experience, health status and duration of coverage of an individual policy or a collection of policies grouped according to anything other than case characteristics or benefit design.

(b) The set of midpoint rates identified in par. (a) shall apply during a specified period which shall not be less than one calendar month.

(2) RATE VARIANCE RESTRICTION. (a) For a new policy issued on or after March 15, 1992, the following table lists the maximum percent a rate may vary from the midpoint rate applicable to policies with the same case characteristics and benefit design characteristics according to the effective date of any rate applied to that policy:

Effective Date of Rate	Maximum Variance from Midpoint Rate
1. March 15, 1992–August 14, 1994	35%
2. August 15, 1994 and after	30%

(b) For a policy issued before March 15, 1992, an insurer shall comply with the rate variance restriction specified in par. (a) 2 no later than August 15, 1994

(3) PREMIUM RATE CHANGES; DOCUMENTATION AND RESTRICTIONS. (a) For the purpose of complying with s. 635.02 (2), Stats., and this subsection, "class of business" means a group of policies with the same or similar benefit design whose rates are based wholly or partly on their aggregate loss experience.

(b) For a policy renewed on or after March 15, 1993, an insurer shall maintain sufficient documentation so that each of the following distinct components can be identified:

1. The percentage change in the new business premium rate measured from the rating period in which the small employer was last rated to the current rating period or, in the case of a class of business for which the insurer is not issuing new policies, the corresponding change in the base premium rate.

2. The percentage change due to adjustments in case characteristics, determined in accordance with the insurer's rate manual or rating procedures.

3. The percentage change due to adjustments in benefit design, determined in accordance with the insurer's rate manual or rating procedures.

4. The percentage change due to such rating factors as claim experience, health status and duration of coverage, determined in accordance with the insurer's rate manual or rating procedures.

(c) Each renewal rate, regardless of whether the rate represents an increase, shall be limited to the previous rate adjusted by the combination of the 4 components specified in par. (b) with the following restrictions on the experience component specified in par. (b) 4.:

1. For a policy issued on or after March 15, 1992, the experience component shall be limited to 15% per year, adjusted proportionately for rating periods of less than one year.

2. For a policy issued before March 15, 1992, subd. 1. applies, except if the premium rate exceeds the midpoint rate by more than the percentage specified in sub. (2) (a) for the applicable period for policies with the same case characteristics and benefit design characteristics, the experience component may not exceed 0%.

(d) For a rate change made before the end of the policy term due to the addition of a new entrant, late enrollee, underwritten individual or a new dependent of an insured employee, par. (c) applies, except that:

1. The new business rate change component specified in par. (b) 1. may not be applied at that time.

2. The experience component specified in par. (b) 4. may not exceed 15% per year, adjusted proportionately to the time remaining in the policy term.

3. The experience component specified in par. (b) 4., when combined with the experience component of the last scheduled rate renewal and any other subsequent rate changes during the current policy term, shall not exceed the limit specified in par. (c) 1. or 2., whichever applies.

(4) ANNUAL PUBLICATION OF RATES. (a) On or before December 1, every small employer insurer shall annually file with the commissioner the small employer insurer's lowest available monthly new business premium rates which will be in effect the following January 1. The filing shall be made on a form provided by the commissioner and shall require all of the following information as may apply to the type of plan offered:

1. For an indemnity plan, the rates shall be based on the insurer's plan that is closest to a plan that features a \$500.00 annual deductible and 80%/20% coinsurance.

2. For a defined network plan, the rates shall be based on a plan which is actuarially equivalent to the features described in subd. 1.

3. For all plans, the rates shall be specified for family and single plans, by group size and by the geographical criteria that are used by the insurer.

4. The commissioner may require additional information be provided in the form as appropriate to implement this subsection.

Note: OCI 26-500, the form described in this subsection may be obtained without charge by contacting the Office of the Commissioner of Insurance PO Box 7873, Madison WI. 53707-7873. The form is also available on the OCI website at oci.wi.gov

(b) Small employer insurers who file rates with the commissioner as described in this subsection will be in compliance with the requirements of s. 635.12, Stats.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92; am. (3) (d) (intro.), Register, November, 1993, No. 455, eff. 2-1-94; CR 02-043: cr. (4), Register October 2002 No. 562, eff. 11-1-02.

Ins 8.54 Guaranteed renewability; cancellation and renewal restrictions.

(1) DEFINITION. (a) In this section, "medically underwritten policy" means a policy that is issued after the small employer insurer has, for purposes of risk selection, used information about the group's claim experience or the health history or medical records of one or more persons eligible for coverage.

(b) Notwithstanding par. (a), a small employer insurer may apply medical underwriting standards to an individual who originally declined and later applies for coverage under a nonmedically underwritten policy without converting that policy to a medically underwritten policy.

(2) CLASS OF BUSINESS. (a) In this section, each of the following is a separate class of business, regardless of variations in policy forms, marketing methods or duration of coverage among small employers in the class of business:

1. All small employers with medically underwritten policies.

2. All small employers with policies that are not medically underwritten.

3. All small employers whose policies constitute a block of business assumed by the small employer insurer under a specific assumption treaty with an insurer that is not an affiliate.

(b) No small employer insurer may establish a class of business other than one specified in par. (a).

(3) GUARANTEED RENEWABILITY. Except as provided in s. 635.07, Stats., a policyholder has the right to renew a policy on the same terms subject to the premium rate restrictions specified in s. Ins 8.52 (3). The subsection does not prohibit a small employer insurer from offering a policyholder renewal with altered benefit design characteristics if the offer is available to all policyholders in the same class of business without regard to claim experience.

Note: 1995 Wis. Act 289 repealed s. 635.07, Stats. See s. 632.749, Stats.

(4) NONRENEWAL OR TERMINATION BASED ON PARTICIPATION REQUIREMENTS. (a) A small employer insurer that intends to non-renew a policy or terminate a policy under s. 635.07 (1) (d), Stats., because the number of eligible employees is less than the number required to keep the policy in force shall do all of the following:

Note: 1995 Wis. Act 289 repealed s. 635.07, Stats. See s. 632.749 (2), Stats.

1. Notify the small employer of its intent to nonrenew or terminate and the reason for the nonrenewal or termination. The notice shall be given as required under s. 631.36, Stats., for a non-renewal or at least 20 days before the termination date for a termination.

2. Offer to continue the small employer's coverage for not less than 60 days after the nonrenewal or termination date in order to allow the small employer to increase the number of eligible employees to the required number.

3. Provide the additional coverage, if the small employer accepts the offer under subd. 2. before the nonrenewal or termination date and pays the premium for the additional coverage at the rate in effect at the time the additional coverage is provided.

(b) A small employer insurer may not nonrenew a policy or terminate a policy under s. 635.07 (1) (d), Stats., if the reason the number of eligible employees is less than the required number is due to an employee's sickness or injury, approved leave of absence or temporary layoff. The small employer insurer may establish participation requirements and reasonable verification procedures as part of the policy or employer agreement.

Note: 1995 Wis. Act 289 repealed s. 635.07, Stats. See s. 632.749 (2), Stats.

(c) A small employer insurer may not take into consideration factors related to an individual small employer's claim experience in deciding whether to nonrenew a policy or terminate a policy under s. 635.07 (1) (d), Stats.

Note: 1995 Wis. Act 289 repealed s. 635.07, Stats. See s. 632.749 (3), Stats.

(d) A small employer insurer that intends to terminate a policy under s. 635.07 (1) (a) to (c) or (e), Stats., shall comply with the notice requirements under s. 631.36 (2) (b) and (c), (4), (6) and (7), Stats.

Note: 1995 Wis. Act 289 repealed s. 635.07, Stats. See s. 632.749 (2), Stats.

(5) NONRENEWAL OF CLASS OF BUSINESS. (a) If a small employer insurer ceases to renew policies issued to all small employers in the same class of business under s. 635.07 (2), Stats., the small employer insurer may not establish any new class of business during the 5-year period beginning with the latest expiration date for policies in effect in the class of business that is not renewed.

Note: 1995 Wis. Act 289 repealed s. 635.07, Stats. See s. 632.749 (3), Stats.

(b) At least one year before a small employer insurer ceases to renew policies under s. 635.07 (2), Stats., the small employer insurer shall provide the office with all of the following information:

Note: 1995 Wis. Act 289 repealed s. 635.07, Stats. See s. 632.749 (3), Stats.

1. The reason for the decision not to renew.

2. The number of small employers and the total number of eligible employees affected by the decision not to renew.

3. The number of small employers in other classes of the small employer insurer's business that are not affected by the decision not to renew.

(c) The commissioner may order an examination under s. 601.43, Stats., in order to determine the premium rate history and obtain information on the profitability of the nonrenewed class of business.

(d) At least one year before a small employer insurer ceases to renew policies under s. 635.07 (2), Stats., the small employer insurer shall provide written notice of that intent to all affected small employers and the insurance regulatory agency in each state in which an affected insured individual resides. The notice shall include all of the following:

Note: 1995 Wis. Act 289 repealed s. 635.07, Stats. See s. 632.749 (3), Stats.

1. The reason for the decision to terminate coverage for the class of business.

2. The date on which coverage will terminate.

(e) In addition to the requirement under par. (d), the small employer insurer shall, at least 60 days but not more than 75 days before the date coverage will terminate, provide each affected small employer with written notice, complying with s. 631.36 (6) and (7), Stats., of the intent not to renew the policy. The notice shall also comply with the notice requirements of ss. 632.79 and 632.897, Stats.

(6) CONVERSION OF ASSUMED CLASS OF BUSINESS. A small employer insurer that assumes a class of business from another small employer insurer shall, by the 2nd renewal date for each policy or one year from the date of assumption, whichever is later, convert each policy in the assumed class of business to a policy with the same or similar benefit design characteristics in another class of business specified under sub. (2) (a).

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92; am. (4) (a) to (c), Register, November, 1993, No. 455, eff. 2-1-94.

Ins 8.56 Certification of compliance; additional information required. (1) The annual certification of compliance required under s. 635.13, Stats., shall be submitted in the form prescribed by the office.

(2) In addition to the annual certification required under sub. (1), the commissioner may require a small employer insurer to furnish additional information including, but not limited to, the following, using the form and method of transmittal prescribed by the commissioner:

(a) Rate manuals or exhibits of all rating factors used for each class of business.

(b) Sample data of small employers including premiums charged and rating factors applied for case characteristics and benefit design characteristics.

(c) An inventory of case characteristics used by the small employer insurer since the last certification date.

(d) An exhibit showing the difference in new business premium rates between the current certification date and the last certification date.

(e) A description of how midpoint rates are determined.

Note: The form required under sub. (1), OCI 26-051, may be obtained from the Office of the Commissioner of Insurance, P. O. Box 7873, Madison, WI 53707-7873.

History: Cr. Register, October, 1992, No. 442, eff. 11-1-92.

Ins 8.59 Small employer insurers shall offer an initial enrollment period to all members of small employer groups; riders and discriminatory coverage are prohibited. (1) A small employer insurer that offers a policy shall provide an initial enrollment period during which each eligible employee and dependent of an eligible employee is entitled to enroll in coverage under the policy.

(2) Except as permitted under sub. (3), a small employer insurer shall provide the same policy coverage to each eligible employee, and dependent of an eligible employee of a small employer, who is covered under a policy.

(3) A small employer insurer may offer, or participate in an offer, to eligible employees of a choice by the eligible employee among 2 or more policies for coverage of the eligible employee and the eligible employee's dependents, but only if:

- (a) The enrollment period is simultaneous for all the policies;
- (b) The eligible employee may choose any one of the offered policies; and
- (c) All the policies offered provide benefits similar to or exceeding the benefits provided under the basic health benefit plan as determined under s. Ins 8.66 (1).

(4) A small employer insurer shall treat coverage under the plan established under ch. 149, Stats., as qualifying coverage for all individuals who enroll during the initial enrollment period, for the purpose of applying s. 635.17 (1) (b), Stats., regardless of the duration of the coverage under the plan.

Note: 1995 Wis. Act 289 repealed s. 635.17, Stats. See s. 632.746 (1), Stats.

History: Cr. Register, November, 1993, No. 455, eff. 2-1-94; correction in (4) made under s. 13.93 (2m) (b) 7., Stats., Register October 2002 No. 562.

Ins 8.60 A small employer insurer may accept an employee's or dependent's waiver of coverage during an initial enrollment period only under limited conditions. (1) A small employer insurer may not issue a policy unless during the initial enrollment period all the eligible employees and dependents of eligible employees elect and are provided coverage under the policy, except a small employer insurer may permit an individual to decline coverage in the initial enrollment period if the small employer insurer determines:

- (a) The individual has coverage under a health benefit plan or other health benefit arrangement, other than the plan established under ch. 149, Stats., that provides benefits similar to or exceeding benefits provided under the basic health benefit plan as determined under s. Ins 8.66 (1);
- (b) The individual elected coverage under another policy during an enrollment period permitted under s. Ins 8.59 (3);
- (c) The individual does not have a risk characteristic or other attribute that would be the sole cause for the small employer insurer to make a decision with respect to premiums or eligibility for a policy that is adverse to the small employer;
- (d) The individual is not enrolled in the plan established under ch. 149, Stats., and the annualized premium contribution to be paid by the eligible employee on behalf of the employee or the dependent of the employee would exceed 10% of the annualized gross earnings of the eligible employee from the employer; or
- (e) The policy that is issued is the basic health benefit plan, the individual is, or is reasonably expected to be, covered under the plan established under ch. 149, Stats., under s. 149.12 (2) (e), Stats., and the individual is in fact covered under the plan established under ch. 149, Stats., effective not later than the effective date of the basic health benefit plan policy.

(2) A small employer insurer may permit an individual to decline coverage under a policy under sub. (1) only if the insurer complies with ss. Ins 8.64 and 8.65.

History: Cr. Register, November, 1993, No. 455, eff. 2-1-94; correction in (1) (a), (d) and (e) made under s. 13.93 (2m) (b) 7., Stats., Register October 2002 No. 562.

Ins 8.61 Small employer insurers shall offer coverage to new entrants. (1) A small employer insurer shall provide under a policy for an enrollment period during which a new entrant is entitled to enroll in coverage under the policy. The small employer insurer shall provide an enrollment period under a policy of at least 30 days after the date the new entrant is notified of the opportunity to enroll. A small employer insurer which offers more than one policy in the initial enrollment period under s. Ins 8.59 (3) shall offer the new entrant the same choice of policies during the new entrant's enrollment period.

(2) A small employer insurer may not accept waiver of coverage under a policy from a new entrant who is currently covered under the plan established under ch. 149, Stats., and shall provide

coverage under the policy to the new entrant, unless the policy is a basic health benefit plan and the new entrant is permitted to continue coverage under the plan established under ch. 149, Stats., under s. 149.12 (2) (e), Stats.

(3) A small employer insurer's policy shall not apply, or permit an employer to apply, a probationary period which must be met before a new entrant is eligible for coverage under a small employer policy, or a similar limitation, that is longer than 6 months.

(4) A small employer insurer may not add coverage restrictions or limitations under a policy because of the risk characteristics of a new entrant.

(5) A small employer insurer may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of s. 635.05, Stats., and s. Ins 8.52 (3) (d).

(6) A small employer insurer shall treat coverage under the plan established under ch. 149, Stats., as qualifying coverage for all new entrants for the purpose of applying s. 635.17 (1) (b), Stats., regardless of the duration of the coverage under the plan.

Note: 1995 Wis. Act 289 repealed s. 635.17, Stats. See s. 632.746 (1), Stats.

History: Cr. Register, November, 1993, No. 455, eff. 2-1-94; corrections in (2) and (6) made under s. 13.93 (2m) (b) 7., Stats., Register October 2002 No. 562.

Ins 8.62 Small employer insurers shall offer an open enrollment for individuals excluded prior to enactment or application of the small employer health insurance law. (1) A small employer insurer shall provide an enrollment period during which underwritten individuals who were excluded or denied coverage prior to the law's effective date are entitled to enroll in coverage under the policy currently held by the small employer. Notice of the enrollment period shall [be] given as required under sub. (4).

(2) A small employer insurer may require an individual who requests enrollment under this section to sign a statement indicating that the individual sought coverage under a policy issued to the employer, other than as a late enrollee, and that the coverage was not offered to the individual. If the individual provides the statement it is presumed that the individual is an underwritten individual and entitled to enroll under this section.

(3) The enrollment period required under this section shall comply with all of the following:

- (a) It shall commence no later than 45 days after December 1, 1993, and shall last for a period of at least 90 days.
- (b) Underwritten individuals who are provided an opportunity to enroll under this section shall be treated as new entrants.
- (c) The terms of coverage offered to an underwritten individual under sub. (1) may exclude coverage for preexisting medical conditions only if the policy currently held by the small employer contains such an exclusion, the exclusion complies with s. 635.17 (1), Stats., and the exclusion period is reduced by the number of days between the date the individual was excluded or denied coverage and the date coverage is provided to the individual under this section.

Note: 1995 Wis. Act 289 repealed s. 635.17, Stats. See s. 632.746 (1), Stats.

(4) A small employer insurer shall provide written notice of the right to enroll under this section to each small employer insured under a policy offered by the insurer. The notice shall be mailed at least 30 days before commencement of the enrollment period and shall clearly describe the rights granted under this section and the process for enrollment of the underwritten individuals in the policy. The insurer shall provide the employer with sufficient copies of the notice to distribute to each eligible employee and shall ask the employer to promptly distribute a copy to each eligible employee. The small employer insurer shall make reasonable efforts to obtain from the small employer certification that the notice was promptly distributed to all eligible employees.

(5) A small employer insurer may assess a risk load to the premium rate associated with an underwritten individual, consistent with the requirements of s. 635.05, Stats., and s. Ins 8.52 (3) (d).

(6) The requirement under sub. (1) to offer an enrollment period applies regardless of whether the small employer insurer required to make the offer was the insurer of the employer when the individual was originally excluded or denied coverage.

History: Cr. Register, November, 1993, No. 455, eff. 12-1-93.

Ins 8.63 Small employer insurers shall offer coverage to late enrollees. (1) A small employer insurer shall provide under a policy for an enrollment period during which a late enrollee is entitled to enroll in coverage under the policy. The small employer insurer shall provide an enrollment period of at least 30 days after the date the late enrollee requests coverage and is notified of the opportunity to enroll.

(2) A small employer insurer may exclude coverage of a late enrollee who elects coverage for no more than 18 months or provide for up to an 18-month preexisting condition exclusion, but if both a period of exclusion from coverage and a preexisting condition exclusion are applied by the small employer insurer under the policy the combined period may not exceed 18 months from the date the individual applies for coverage under the policy. A small employer insurer may require that the late enrollee remain continuously employed by, or remain a dependent of an eligible employee continuously employed by, the small employer for the entire period of exclusion permitted under this subsection. A small employer insurer may not impose a preexisting condition exclusion under s. 635.17 (1), Stats., in addition to an exclusion permitted under this subsection.

Note: 1995 Wis. Act 289 repealed s. 635.17, Stats. See s. 632.746 (1), Stats.

(3) A small employer insurer may assess a risk load to the premium rate associated with a late entrant, consistent with the requirements of s. 635.05, Stats., and s. Ins 8.52 (3) (d).

History: Cr. Register, November, 1993, No. 455, eff. 2-1-94.

Ins 8.64 Small employer insurers may not participate with a small employer to coerce, or discriminate among, eligible employees or dependents. (1) A small employer insurer may not accept a waiver of coverage, if the insurer, or an insurance intermediary for the insurer, reasonably should know that the small employer pressured or unfairly induced the eligible employee or dependent of an eligible employee to decline coverage due to the individual's risk characteristics.

(2) An insurance intermediary shall notify a small employer insurer in writing, prior to submitting an application for coverage with the insurer on behalf of a small employer, or prior to transmittal of a waiver, of any circumstances that would indicate that the small employer pressured or unfairly induced an eligible employee or dependent of an eligible employee to decline coverage due to the individual's risk characteristics.

History: Cr. Register, November, 1993, No. 455, eff. 2-1-94.

Ins 8.65 A small employer insurer shall require small employers to provide documentation to establish that waivers of coverage are voluntary and permitted.

(1) A small employer insurer shall require each small employer that applies for a policy, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees of the small employer. The small employer insurer shall require the small employer to provide appropriate supporting documentation, such as the state unemployment or worker's compensation quarterly reporting forms, to verify the information required under this subsection.

(2) A small employer insurer shall secure a waiver signed by the eligible employee on behalf of the employee or the dependent of the employee with respect to each eligible employee, and each dependent of an eligible employee, who declines an offer of coverage under a policy, whether during an initial enrollment period, as a new entrant or as an underwritten individual. The small employer insurer shall include on the waiver and require:

(a) A certification that the individual who declined coverage was informed of the availability of coverage under the policy;

(b) That the reason for declining coverage be stated; and

(c) A written warning of the consequences which may be imposed on late enrollees.

(3) A small employer insurer shall obtain, with respect to each individual who submits a waiver under sub. (2) in connection with an initial enrollment period, information sufficient to establish that the waiver may be accepted under s. Ins 8.60 (1).

(4) A small employer insurer shall maintain waivers required under sub. (2), the information required to be obtained under sub. (3) and notifications under s. Ins 8.64 (2), for a period of 3 years or until the policy terminates, whichever is later.

(5) A small employer insurer may not issue coverage to a small employer that refuses to provide the list required under sub. (1), a waiver required under sub. (2) or information required under sub. (3).

History: Cr. Register, November, 1993, No. 455, eff. 2-1-94.

Ins 8.66 Qualifying coverage for portability and late enrollees; transition. (1) For the purpose of determining whether a health benefit plan or other health benefit arrangement is qualifying coverage under s. 635.17, Stats., or under this subchapter:

Note: 1995 Wis. Act 289 repealed s. 635.17, Stats. See s. 632.745 (4), Stats.

(a) A health insurance policy, certificate or other health benefit arrangement is employer-based if an employer sponsors the plan or arrangement or makes a contribution to the plan or arrangement.

(b) A health insurance policy, certificate or other benefit arrangement provides benefits similar to or exceeding the benefits provided under the basic health benefit plan if the policy, certificate or other benefit arrangement provides benefits that:

1. Have an actuarial value as considered for a normal distribution of groups that is not substantially less than the actuarial value of the basic health benefit plan; or

2. Provides coverage for hospitalization and physician services that is substantially similar to or exceeds the coverage for those services in the basic health benefit plan.

(c) A small employer insurer shall evaluate a previous or existing policy, certificate or other benefit arrangement taken as a whole and shall not base its determination on the fact that one or more portions of the previous or existing policy, certificate or benefit arrangement provides less coverage than the comparable portion of the basic health benefit plan.

(2) For the purposes of s. 635.17 (1) (b), 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.

Note: 1995 Wis. Act 289 repealed s. 635.17, Stats. See s. 632.746 (1) and (3), Stats.

(3) To the extent necessary to comply with this section and s. 635.17, Stats., a small employer insurer shall ascertain the source of previous or existing coverage of each eligible employee and each dependent of an eligible employee at the time the employee or dependent initially enrolls in the health benefit plan provided by the small employer insurer. The small employer insurer shall contact the source of previous or existing coverage to resolve any questions about the benefits or limitations related to the previous or existing coverage.

Note: 1995 Wis. Act 289 repealed s. 635.17, Stats. See s. 632.746, Stats.

(4) No small employer insurer may renew or issue a policy after November 30, 1993, unless the policy includes a provision complying with s. 635.17 (1) (b), Stats., as to qualifying coverage defined in s. 635.02 (5m) (b) and (c), Stats., in addition to qualifying coverage defined in s. 635.02 (5m) (a), Stats. An insurer shall administratively comply with s. 635.17 (1) (b), Stats., for all policies in force on or after July 1, 1993, with respect to qualifying

coverage defined under s. 635.02 (5m) (b) and (c), Stats., for all individuals who commence coverage under a policy after June 30, 1993. All small employer insurers shall establish and disseminate policies and procedures designed to ensure compliance with this subsection by not later than December 1, 1993.

Note: 1995 Wis. Act 289 repealed ss. 635.02 (5m) and 635.17, Stats. See ss. 632.745 (4) and 632.746 (1), Stats.

(5) An insurer, on request, shall provide to the current insurer of a small employer copies of pertinent health benefit plan provisions, a statement of coverage available and other information reasonably necessary to enable the current insurer to comply with subs. (1) to (3).

History: Cr. Register, November, 1993, No. 455, eff. 12-1-93.

Ins 8.67 Restrictive riders prohibited. A restrictive rider, endorsement or other provision that would violate s. 635.17 (3) (b), Stats., and that was in force on May 12, 1992, may not remain in force beyond the first renewal date of the policy and a small employer insurer shall delete the rider, endorsement or other provision after the law's effective date.

Note: 1995 Wis. Act 289 repealed s. 635.17, Stats. See s. 632.748 (1), Stats.

History: Cr. Register, November, 1993, No. 455, eff. 2-1-94.

Ins 8.68 Fair marketing standards. (1) (a) Unless otherwise permitted under par. (b), (c) or (d), a small employer insurer shall actively market its health benefit plans to all small employers and without regard to the size of the small employer group by:

1. Actively marketing in each segment of the small employer market the basic health benefit plan and at least one form of a policy which provides benefits which materially exceed benefits provided under the basic health benefit plan.

2. Actively marketing in each area of the state the basic health benefit plan and at least one form of a policy which provides benefits which materially exceed benefits provided under the basic health benefit plan, except a small employer insurer which is, and is likely to remain, in compliance with s. Ins 8.69 may:

a. Limit marketing to the provider service areas for the health maintenance organization or preferred provider plans if it limits the policies it offers to the basic health benefit plan and policies which are health maintenance organization plans or preferred provider plans; or

b. Limit its marketing of policies to selected areas which the small employer insurer can demonstrate by clear and convincing evidence are selected for justifiable business reasons other than desirable demographic characteristics related to risk selection.

(b) A small employer insurer may limit marketing and issuance of the basic health benefit plan under s. 635.26 (2m) or (4), Stats., or may limit marketing and issuance of other forms of policies, or both, to a particular segment of the market, only if the segment is not based on the size of the small employer group and the small employer insurer:

Note: 1997 Wis. Act 27 repealed s. 635.26, Stats. See s. 635.19 (2), Stats.

1. Files with the commissioner on or after February 1, 1994, in the form prescribed by the commissioner, a request for approval to limit its marketing of policies;

2. Obtains prior written approval from the commissioner, after the commissioner finds approval is consistent with the purpose of ch. 635, Stats., and the approval is not rescinded;

3. Complies with this chapter and ch. 635, Stats., with respect to the entire market segment;

4. Complies with s. Ins 8.69 computed based on the entire market, not only the market segment targeted by the small employer insurer; and

5. Does not use targeting of a particular market segment as a subterfuge for applying underwriting criteria, including, but not limited to, selling only through a trust or association which limits membership based on health or based on factors which are

designed to limit the enrollment of individuals with health conditions.

(c) Until February 1, 1995, a small employer insurer may limit marketing of health benefit plans to small employers based on the size of the small employer group but:

1. Only according to the small employer insurer's marketing practices in effect on July 1, 1993; and

2. Only if the small employer insurer issues the basic health benefit plan to small employer groups of any size and is in compliance with s. Ins 8.69.

(d) A small employer insurer may actively market only the basic health benefit plan but only if it does not sell or market any other form of a policy in this state.

(2) A small employer insurer shall market the basic health benefit plan using at least the same sources and methods of distribution that it uses to market policies other than the basic health benefit plan. A small employer insurer shall authorize all insurance intermediaries who are authorized to market its health benefit plans to also sell its basic health benefit plan.

(3) A small employer insurer shall offer the basic health benefit plan to a small employer that applies for health insurance coverage from the small employer insurer. The small employer insurer may provide the offer directly to the small employer or may deliver it through an insurance intermediary. The offer shall be in writing and shall include at least all the following information:

(a) A general description of the benefits contained in the basic health benefit plan.

(b) That an individual who would otherwise be covered under the basic health benefit plan and who has a severe and chronic or long-lasting physical or mental illness or disability may be eligible for coverage under the plan established under ch. 149, Stats., under s. 149.12 (2) (e), Stats.

(c) That an individual described under par. (b) who elects to be covered under the plan established under ch. 149, Stats., and who subsequently terminates coverage under the plan:

1. Will not be eligible for continuation of coverage or a conversion policy;

2. Will be eligible only as a late enrollee under the health benefit plan then held by the small employer; and

3. May, as a late enrollee, be subject to the exclusion permitted under s. Ins 8.63 (2).

(d) Information describing how the small employer may enroll in the plan.

(4) A small employer insurer shall provide written notice of the information described under sub. (3) (a) to (c) to each small employer who applies for a basic health benefit plan within 10 working days of the date the small employer insurer receives the small employer's application. The small employer insurer shall provide the notice directly or through an authorized insurance intermediary. The small employer insurer shall provide the employer with sufficient copies of the notice to distribute to each eligible employee and shall ask the employer to promptly distribute a copy to each eligible employee. The small employer insurer shall make reasonable efforts to obtain, within 20 business days after the small employer insurer issues a basic health benefit plan to a small employer, certification that the small employer promptly distributed the notice to all eligible employees.

(5) (a) A small employer insurer shall provide a price quote for the basic health benefit plan to a small employer directly or through an authorized insurance intermediary within 15 working days of receiving a request for a quote and the information necessary to provide the quote. A small employer insurer shall notify a small employer directly or through an authorized insurance intermediary within 7 working days of receiving a request for a price quote of any additional information needed by the small employer insurer to provide the quote.

(b) A small employer insurer may not apply more stringent or detailed requirements related to the application process for the basic health benefit plan than are applied for other health benefit plans offered by the insurer to groups of equivalent size.

(6) (a) If a small employer insurer denies coverage under a health benefit plan to a small employer on the basis of a risk characteristic, the denial shall be in writing and shall state with specificity the reasons for the denial, subject to any restrictions related to confidentiality of medical information. The written denial shall be accompanied by a written explanation of the availability of the basic health benefit plan from the small employer insurer. The explanation shall include at least the following:

1. A general description of the benefits contained in each plan;
2. A price quote for each plan; and
3. Information describing how the small employer may enroll in the plan.

(b) A small employer insurer shall provide the written information described in par. (a) within the time periods provided under sub. (5) (a) directly to the small employer or delivered through an authorized insurance intermediary.

(c) The price quote required under par. (a) 2. shall be for the managed care option which will result in the lowest-priced basic health benefit plan for which the small employer is eligible, if the small employer insurer has such an option available in the area where the small employer is located.

(7) A small employer insurer shall establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of small employer health benefit plans in this state. The toll-free telephone service is not required to be dedicated to this purpose. The service shall provide information to callers on how to apply for coverage from the insurer. The information may include the names and phone numbers of insurance intermediaries actively marketing in the geographic area proximate to the caller or other information that is reasonably designed to assist the caller to locate an authorized insurance intermediary or to otherwise apply for coverage.

(8) A small employer insurer may not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer insurer, except that, if an association or group requires membership in the association or other group as a condition for accepting a small employer into a particular health benefit plan, the small employer insurer may apply the requirement if:

- (a) The requirement is reasonable;
- (b) The requirement is not intended to and does not discourage or prevent acceptance of small employers applying for the basic health benefit plan;
- (c) The requirement is not related to the health status or claim experience of the small employer or employees or dependents of employees of small employers;
- (d) The requirement is applied consistently to all small employers applying for coverage; and
- (e) The small employer insurer permits all small employers who join the association or group to apply for a health benefit plan.

(9) A small employer insurer may not require, as a condition to the offer or sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service or purchase or qualify for a health benefit plan which includes coverage other than health coverage.

(10) (a) An insurer offering individual or group health benefit plans or coverage under a trust or association health benefit plan in this state shall investigate and determine whether the plans are subject to this subchapter and ch. 635, Stats. An insurer shall obtain the following information from applicants for individual and group health benefit plans at the time of application:

1. Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement;

2. Whether or not any portion of the premium will be collected by or with the cooperation of a small employer; and

3. Whether or not the prospective policyholder, certificate holder or any prospective insured individual intends to treat the health benefit plan as part of a plan or program under Section 162, Section 125 or Section 106 of the United States internal revenue code.

(b) If a small employer insurer fails to comply with par. (a), the small employer insurer is deemed to be on notice of any information that could reasonably have been obtained if the small employer insurer had complied with par. (a).

(c) An insurer is not relieved from complying with ch. 635, Stats., and there is no presumption that ch. 635, Stats., does not apply merely because the insurer has complied with the minimum obligation to investigate the status of applicants imposed under this subsection.

(11) No small employer insurer may permit an insurance intermediary to advise, and no insurance intermediary may advise, a small employer whether the insurer may accept the small employer's application for coverage under a health benefit plan based on claims experience or health conditions of the group except after submittal of an application and review by the insurer.

(12) A small employer insurer shall annually file information with the commissioner related to health benefit plans issued by the small employer insurer to small employers in this state in the form prescribed by the commissioner.

Note: Copies of forms referred to in this section may be obtained without charge from the Office of the Commissioner of Insurance by sending a written request to P. O. Box 7873, Madison, Wisconsin 53707-7873.

History: Cr. Register, November, 1993, No. 455, eff. 2-1-94; correction in (10) (a) made under 13.93 (2m) (b) 7., Register, March, 2000, No. 531; corrections in (3) (b) and (c) (intro.) made under s. 13.93 (2m) (b) 7., Stats., Register October 2002 No. 562.

Ins 8.69 Minimum standards for market share of basic health benefit plans in force; exemption from guarantee issuance of the basic health benefit plan.

(1) No small employer insurer may have a basic market share ratio which is significantly less than the basic market share ratio for all small employer insurers unless the insurer establishes by clear and convincing evidence that the reason the basic market share ratio is significantly less is because:

- (a) Of a specific practice or condition that is beyond the control of the insurer; or
- (b) The insurer uses risk characteristics to underwrite applications for policies to a substantially lesser extent than most other small employer insurers.

(2) No small employer insurer may have a market share ratio which is significantly less than the market share ratio for all small employer insurers unless the small employer insurer establishes by clear and convincing evidence that the reason the market share ratio is significantly less is because:

- (a) Of a specific practice or condition that is beyond the control of the insurer; or
- (b) The insurer uses risk characteristics to underwrite applications for policies to a substantially lesser extent than most other small employer insurers.

(3) For the purpose of this section:

(a) A small employer insurer's basic market share ratio is presumed to be significantly less than the basic market share ratio for all small employer insurers if the small employer insurer's basic market share ratio is less than a number equal to $q-2$. For the purpose of this paragraph:

1. 'm' is the number of basic health benefit plans the small employer insurer has in force; and

2. 'q' is the basic market share ratio for all small employer insurers.

(b) A small employer insurer's market share ratio is presumed to be significantly less than the market share ratio for all small employer insurers if the small employer insurer's market share ratio is less than a number equal to $p-2$. For the purpose of this paragraph:

1. 'n' is the number of policies the small employer insurer has in force; and

2. 'p' is the market share ratio for all small employer insurers.

(4) A small employer insurer shall submit an application for an exemption under s. 635.26 (3) (a), Stats., in the form prescribed by the commissioner. Any application for an exemption under s. 635.26 (3) (a), Stats., shall include the small employer insurer's basic market share ratio and market share ratio and shall address whether the small employer insurer has ratios which are, or are likely to be, significantly higher than the ratios for all small employer insurers and the reasons why the small employer insurer ratios are, or are likely to be, significantly higher than the ratio for all small employer insurers.

Note: 1997 Wis. Act 27 repealed s. 635.26, Stats. See s. 635.19 (6), Stats.

(5) Each small employer insurer shall file, in the form prescribed by the commissioner:

(a) Within 45 days after the end of each quarter calendar year in calendar years 1993, 1994 and 1995:

1. The number of risk characteristic basic health benefit plans it has in force at the end of the previous quarter calendar year;

2. The number of risk characteristic basic health benefit plans it issued in the previous quarter calendar year;

3. The number of basic health benefit plans it has in force at the end of the previous quarter calendar year;

4. The number of basic health benefit plans it issued in the previous quarter calendar year;

5. The total number of policies it has in force at the end of the previous quarter calendar year;

6. The total number of policies it issued in the previous quarter calendar year;

7. Its basic market share ratio for the previous quarter calendar year;

8. Its market share ratio for the previous quarter calendar year;

9. The total number of applications for any policy which the small employer insurer received in the previous quarter calendar year, regardless of whether, or what type of, a policy was issued, and which the small employer insurer:

a. Rejected, or would have rejected, for each policy available from the small employer insurer, other than the basic health benefit plan or a policy that does not provide benefits similar to or exceeding benefits provided under the basic health benefit plan; or

b. Assigned, or would have assigned, a rate for each policy available from the small employer insurer, other than the basic health benefit plan or a policy that does not provide benefits similar to or exceeding benefits provided under the basic health benefit plan, which exceeds the new business premium rate for the policy by 15% or more; and

10. The total number of applications for any policy which the small employer insurer received in the previous quarter calendar year, regardless of whether, or what type of, a policy was issued.

(b) By March 1 of each year:

1. The number of risk characteristic basic health benefit plans it had in force at the end of the previous calendar year;

2. The number of risk characteristic basic health benefit plans it issued in the previous calendar year;

3. The number of basic health benefit plans it had in force at the end of the previous calendar year;

4. The number of basic health benefit plans it issued in the previous calendar year;

5. The total number of policies it had in force at the end of the previous calendar year;

6. The total number of policies it issued in the previous calendar year;

7. Its basic market share ratio for the previous calendar year;

8. Its market share ratio for the previous calendar year;

9. The total number of applications for any policy which the small employer insurer received in the previous calendar year, regardless of whether, or what type of, a policy was issued, and which the small employer insurer:

a. Rejected, or would have rejected, for each policy available from the small employer insurer, other than the basic health benefit plan or a policy that does not provide benefits similar to or exceeding benefits provided under the basic health benefit plan; or

b. Assigned, or would have assigned, a rate for each policy available from the small employer insurer, other than the basic health benefit plan or a policy that does not provide benefits similar to or exceeding benefits provided under the basic health benefit plan, which exceeds the new business premium rate for the policy by 15% or more; and

10. The total number of applications for any policy which the small employer insurer received in the previous calendar year, regardless of whether, or what type of, a policy was issued.

(6) A small employer insurer shall obtain sufficient information to comply with sub. (5) and shall maintain the information and the documentation required under sub. (5) for 3 years or until the issued policy, if any, terminates, whichever is later.

(7) A small employer insurer shall establish procedures for determining whether a basic health benefit plan is a risk characteristic basic health benefit plan and shall document the basis for each such determination.

Note: Copies of forms referred to in this section may be obtained without charge from the Office of the Commissioner of Insurance by sending a written request to P. O. Box 7873, Madison, Wisconsin 53707-7873.

History: Cr. Register, November, 1993, No. 455, eff. 2-1-94.

Subchapter IV — Basic Health Benefit Plan For Small Employers

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

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93; correction in (intro.) made under 13.93 (2m) (b) 7., Stats., Register, March, 2000, No. 531.

Ins 8.71 Definitions. (1) The definitions in s. 635.02, 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.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93; correction in (1) made under s. 13.93 (2m) (b) 7., Stats., Register April 2004 No. 580.

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 42 CFR 416.2.

(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. 50.49, 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.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93; corrections in (3) and (6) made under s. 13.93 (2m) (b) 7., Stats., Register October 2002 No. 562.

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).

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

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.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

Ins 8.75 Limitations and restrictions. (1) PREEXISTING CONDITIONS. Section 635.17 (1), Stats., applies to a plan subject to this subchapter.

Note: 1995 Wis. Act 289 repealed s. 635.17, Stats. See s. 632.746, Stats.

(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.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

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.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

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. (4) 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.

(3) **COINSURANCE.** Except as provided in sub. (4) 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.

(4) **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. (2) and (3). 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.

(5) **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.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

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.

Note: 1997 Wis. Act 27 repealed s. 635.20.

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

Note: 1995 Wis. Act 289 repealed s. 635.02 (5m).

(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 employee is eligible to enroll in the small employer's plan.

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

(b) An eligible employee 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.

(c) Section Ins 8.63 (2) applies to an eligible employee or dependent who does not enroll in a small employer's plan within the period specified in par. (a) or (b).

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

Note: 1997 Wis. Act 27 repealed s. 635.20.

(b) If a plan permits employees other than those defined as eligible employees 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 employees. If the small employer elects not to contribute, the small employer shall withhold the entire amount of the premium from the earnings of each employee permitted to participate, as provided in s. 635.254 (2), Stats.

Note: 1997 Wis. Act 27 repealed ss. 635.20 and 635.254. See ss. 632.745 (5) and 635.19 (4), Stats.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93; cr. (3) (c), Register, November, 1993, No. 455, eff. 2-1-94.

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 (2) or the percentage of an insured's coinsurance under s. Ins 8.77 (3) if the insured uses a nonparticipating health care provider.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

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.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.

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 October 1, 1993.

Note: 1997 Wis. Act 27 repealed s. 635.26, Stats. See s. 635.19 (2), Stats.

(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 December 1, 1993 unless its basic health benefit plan policy form has been filed with and approved by the commissioner of insurance under s. 631.20, Stats.

Note: 1997 Wis. Act 27 repealed s. 635.26, Stats. See 635.19 (2), Stats.

History: Cr. Register, June, 1993, No. 450, eff. 7-1-93.