State of Wisconsin
1997 - 1998 LEGISLATURE

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SENATE SUBSTITUTE AMENDMENT 1,

TO 1997 SENATE BILL 218

October 22, 1997 – Offered by Senator MOEN.

AN ACT ***to repeal*** 185.983 (1g) and chapter 635; ***to amend*** 40.51 (8), 40.51 (8m), 60.23 (25), 66.184, 111.91 (2) (k), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 600.01 (2) (b), 613.03 (3), 625.12 (2), 628.34 (3) (a), 628.34 (3) (b), 632.745 (intro.), 632.745 (7), 632.745 (18) (intro.), 632.745 (27), 632.746 (title), 632.746 (1) (a), 632.746 (2), 632.746 (3) (a), (b) and (d) 1., 632.746 (6), 632.746 (7) (a) (intro.), (b) (intro.) and 1. and (c) 1., 632.747 (title), 632.748 (title), 632.748 (4) (c), 632.749 (title), 632.749 (2) (e), 632.76 (2) (a) and 632.896 (4); ***to repeal and recreate*** 632.745 (25); and ***to create*** 632.745 (1m), 632.745 (2m), 632.745 (3m), 632.745 (7m), 632.745 (18m), 632.745 (19m), 632.745 (23m), 632.745 (23p), 632.745 (26m), 632.7465, 632.7491, 632.7492, 632.7494, 632.7497, 632.7498 and 632.7499 of the statutes; **relating to:** health insurance coverage requirements, including preexisting condition exclusions, guaranteed issue, portability, rating restrictions and fair marketing standards; collective

bargaining of certain health care coverage requirements; granting rule–making authority; requiring the exercise of rule–making authority; and providing an exemption from rule–making procedures.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes, as affected by 1997 Wisconsin Act 27, section 1324m, is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.7491, 632.87 (3) to (5), 632.895 (5m) and (8) to (13) and 632.896.

SECTION 2. 40.51 (8m) of the statutes, as affected by 1997 Wisconsin Act 27, section 1325m, is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 632.746 (1) to (8) and (10), 632.7465, 632.747 ~~and~~, 632.748, 632.7491, 632.7492, 632.7497 and 632.895 (11) to (13).

SECTION 3. 60.23 (25) of the statutes, as affected by 1997 Wisconsin Act 27, section 2178p, is amended to read:

60.23 **(25)** SELF–INSURED HEALTH PLANS. Provide health care benefits to its officers and employes on a self–insured basis if the self–insured plan complies with ss. 631.89, 631.90, 631.93 (2), 632.746 (1), (2), (3) (a), (b), (c), (d) 1. and (e), (6), (7) and (10) (a) 2. and (b) 2., 632.747 (3), 632.87 (4) and (5), 632.895 (9) and (11) to (13) and 632.896.

SECTION 4. 66.184 of the statutes, as affected by 1997 Wisconsin Act 27, section 2210m, is amended to read:

66.184 Self–insured health plans. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employes on a self–insured basis, the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (1), (2), (3) (a), (b), (c), (d) 1. and (e), (6), (7) and (10) (a) 2. and (b) 2., 632.747 (3), 632.87 (4) and (5), 632.895 (9) to (13), 632.896, 767.25 (4m) (d) and 767.51 (3m) (d).

SECTION 5. 111.91 (2) (k) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

111.91 **(2)** (k) Compliance with the health benefit plan requirements under ss. 632.746 (1) to (8) and (10), 632.7465, 632.747 ~~and~~, 632.748, 632.7491, 632.7492 and 632.7497.

SECTION 6. 120.13 (2) (g) of the statutes, as affected by 1997 Wisconsin Act 27, section 2860f, is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (1), (2), (3) (a), (b), (c), (d) 1. and (e), (6), (7) and (10) (a) 2. and (b) 2., 632.747 (3), 632.87 (4) and (5), 632.895 (9) to (13), 632.896, 767.25 (4m) (d) and 767.51 (3m) (d).

SECTION 7. 185.981 (4t) of the statutes, as affected by 1997 Wisconsin Act 27, section 3133m, is amended to read:

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.89, 632.72 (2), 632.745 to ~~632.749~~ 632.7492, 632.7497 to 632.7499, 632.87 (2m), (3), (4) and (5), 632.895 (10) to (13) and 632.897 (10) and chs. 149 and 155.

SECTION 8. 185.983 (1) (intro.) of the statutes, as affected by 1997 Wisconsin Act 27, section 3134m, is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.89, 631.93, 632.72 (2), 632.745 to ~~632.749~~ 632.7492, 632.7497 to 632.7499, 632.775, 632.79, 632.795, 632.87 (2m), (3), (4) and (5), 632.895 (5) and (9) to (13), 632.896 and 632.897 (10) and chs. 609, 630, ~~635,~~ 645 and 646, but the sponsoring association shall:

SECTION 9. 185.983 (1g) of the statutes is repealed.

SECTION 10. 600.01 (2) (b) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

600.01 **(2)** (b) Group or blanket insurance described in sub. (1) (b) 3. and 4. is not exempt from ss. 632.745 to ~~632.749~~ 632.7492 or 632.7497 to 632.7499 or ch. 633 ~~or 635~~.

SECTION 11. 613.03 (3) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

613.03 **(3)** APPLICABILITY OF INSURANCE LAWS. Except as otherwise specifically provided, service insurance corporations organized or operating under this chapter are subject to ss. 610.01, 610.11, 610.21, 610.23 and 610.24 and chs. 600, 601, 609, 617, 620, 623, 625, 627, 628, 631, 632~~, 635~~ and 645 and to no other insurance laws.

SECTION 12. 625.12 (2) of the statutes is amended to read:

625.12 **(2)** CLASSIFICATION. ~~Risks~~ Subject to s. 632.7497, risks may be classified in any reasonable way for the establishment of rates and minimum premiums, except that no classifications may be based on race, color, creed or national origin, and classifications in automobile insurance may not be based on physical condition

or developmental disability as defined in s. 51.01 (5). Subject to ~~s.~~ ss. 632.365 and 632.7497, rates thus produced may be modified for individual risks in accordance with rating plans or schedules that establish reasonable standards for measuring probable variations in hazards, expenses, or both. Rates may also be modified for individual risks under s. 625.13 (2).

SECTION 13. 628.34 (3) (a) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

628.34 **(3)** (a) No insurer may unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage except on the basis of classifications related to the nature and the degree of the risk covered or the expenses involved, subject to ss. 632.365, ~~632.745 and~~ 632.746, 632.748, 632.7494 and 632.7497. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket or franchise policy, and terms are not unfairly discriminatory merely because they are more favorable than in a similar individual policy.

SECTION 14. 628.34 (3) (b) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

628.34 **(3)** (b) No insurer may refuse to insure or refuse to continue to insure, or limit the amount, extent or kind of coverage available to an individual, or charge an individual a different rate for the same coverage because of a mental or physical disability except when the refusal, limitation or rate differential is based on either sound actuarial principles supported by reliable data or actual or reasonably anticipated experience, subject to ss. 632.746 to 632.749, 632.7494, 632.7495 and 632.7497.

SECTION 15. 632.745 (intro.) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

632.745 Coverage requirements for group and individual health benefit plans; definitions. (intro.) In this section and ss. 632.746 to ~~632.7495~~ 632.7499:

SECTION 16. 632.745 (1m) of the statutes is created to read:

632.745 **(1m)** "Base premium rate" means the lowest premium rate chargeable under a rating system to employers or individuals with similar case characteristics and the same or similar benefit design characteristics.

SECTION 17. 632.745 (2m) of the statutes is created to read:

632.745 **(2m)** "Benefit design characteristics" means covered services, cost sharing, utilization management, managed care networks and other features that differentiate plan or coverage designs.

SECTION 18. 632.745 (3m) of the statutes is created to read:

632.745 **(3m)** "Case characteristics" means the age, gender, geographic location and tobacco use of the individuals covered under a health benefit plan.

SECTION 19. 632.745 (7) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

632.745 **(7)** "Enrollment date" means, with respect to an individual covered under a self–insured health plan, group health plan or health insurance, the date of enrollment of the individual under the plan or insurance or, if earlier, the first day of the waiting period for such enrollment.

SECTION 20. 632.745 (7m) of the statutes is created to read:

632.745 **(7m)** "Established geographic service area" means a geographic area within which an insurer provides coverage and that has been approved by the commissioner.

SECTION 21. 632.745 (18) (intro.) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

632.745 **(18)** (intro.) "Late enrollee" means, with respect to coverage under a self–insured health plan, a group health plan or health insurance coverage, a participant, beneficiary or individual who enrolls under the plan or coverage at any time other than during any of the following:

SECTION 22. 632.745 (18m) of the statutes is created to read:

632.745 **(18m)** "Midpoint rate" means the arithmetic average of the base premium rate and the corresponding highest premium rate.

SECTION 23. 632.745 (19m) of the statutes is created to read:

632.745 **(19m)** "New business premium rate" means the premium rate charged or offered to employers or individuals with similar case characteristics for newly issued health insurance with the same or similar benefit design characteristics.

SECTION 24. 632.745 (23m) of the statutes is created to read:

632.745 **(23m)** "Rating period" means the period, determined by an insurer, during which a premium rate established by the insurer remains in effect.

SECTION 25. 632.745 (23p) of the statutes is created to read:

632.745 **(23p)** "Restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on obtaining services or articles from health care providers that have contracted with the insurer to provide health care services or articles to covered individuals.

SECTION 26. 632.745 (25) of the statutes, as affected by 1997 Wisconsin Act 27, is repealed and recreated to read:

632.745 **(25)** "Small employer" means, with respect to a calendar year and a plan year, an employer that employed an average of at least 2 but not more than 50 employes on business days during the preceding calendar year, or that is reasonably expected to employ an average of at least 2 but not more than 50 employes on business days during the current calendar year if the employer was not in existence during the preceding calendar year, and that employs at least 2 employes on the first day of the plan year.

SECTION 27. 632.745 (26m) of the statutes is created to read:

632.745 **(26m)** "Student–only medical plan" means a limited nonmedically underwritten individual or group health benefit plan that is guaranteed renewable while the covered person is enrolled as a regular, full–time undergraduate or graduate student at an accredited technical or trade school, college or university and to which any of the following applied at issuance:

(a) The student was not insured under a health benefit plan.

(b) The student was eligible for coverage under a health benefit plan of his or her parent, stepparent or guardian but was unable to access the full health benefits of the plan due to limitations in the plan's geographic service area.

SECTION 28. 632.745 (27) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

632.745 **(27)** "Waiting period" means, with respect to a self–insured health plan, a group health plan or health insurance coverage and an individual who is a potential participant or beneficiary in the self–insured health plan or group health plan or who is potentially covered by the health insurance coverage, the period that

must pass with respect to the individual before the individual is eligible for benefits under the terms of the plan or coverage.

SECTION 29. 632.746 (title) of the statutes, as created by 1997 Wisconsin Act 27, is amended to read:

632.746 (title) **Preexisting ~~condition~~ conditions; portability; restrictions; and special enrollment periods for group health benefit plans.**

SECTION 30. 632.746 (1) (a) of the statutes, as created by 1997 Wisconsin Act 27, is amended to read:

632.746 **(1)** (a) Subject to subs. (2) and (3), a self–insured health plan or an insurer that offers a group health benefit plan may, with respect to a participant or beneficiary under the plan, impose a preexisting condition exclusion only if the exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6–month period ending on the participant's or beneficiary's enrollment date under the plan.

SECTION 31. 632.746 (2) of the statutes, as created by 1997 Wisconsin Act 27, is amended to read:

632.746 **(2)** ~~An~~ A self–insured health plan or an insurer offering a group health benefit plan may not treat genetic information as a preexisting condition under sub. (1) without a diagnosis of a condition related to the information.

(b) ~~An~~ A self–insured health plan or an insurer offering a group health benefit plan may not impose a preexisting condition exclusion relating to pregnancy as a preexisting condition.

(c) Subject to par. (e), a self–insured health plan or an insurer offering a group health benefit plan may not impose a preexisting condition exclusion with respect to

an individual who is covered under creditable coverage on the last day of the 30–day period beginning with the day on which the individual is born.

(d) Subject to par. (e), a self–insured health plan or an insurer offering a group health benefit plan may not impose a preexisting condition exclusion with respect to an individual who is adopted or placed for adoption before attaining the age of 18 years and who is covered under creditable coverage on the last day of the 30–day period beginning with the day on which the individual is adopted or placed for adoption. This paragraph does not apply to coverage before the day on which the individual is adopted or placed for adoption.

(e) Paragraphs (c) and (d) do not apply to an individual after the end of the first continuous period during which the individual was not covered under any creditable coverage for at least 63 days. For purposes of this paragraph, any waiting period or affiliation period for coverage under a self–insured health plan, group health plan or group health benefit plan shall not be taken into account in determining the period before enrollment in the self–insured health plan, group health plan or group health benefit plan.

SECTION 32. 632.746 (3) (a), (b) and (d) 1., of the statutes, as created by 1997 Wisconsin Act 27, are amended to read:

632.746 **(3)** (a) The length of time during which any preexisting condition exclusion under sub. (1) may be imposed shall be reduced by the aggregate of the participant's or beneficiary's periods of creditable coverage on his or her enrollment date under the self–insured health plan or group health benefit plan.

(b) With respect to enrollment of an individual under a self–insured health plan, a group health plan or a group health benefit plan, a period of creditable coverage after which the individual was not covered under any creditable coverage

for a period of at least 63 days before enrollment in the self–insured health plan, group health plan or group health benefit plan may not be counted. For purposes of this paragraph, any waiting period or affiliation period for coverage under the self–insured health plan, group health plan or group health benefit plan shall not be taken into account in determining the period before enrollment in the self–insured health plan, group health plan or group health benefit plan.

(d) 1. ~~An~~ A self–insured health plan or an insurer offering a group health benefit plan shall count a period of creditable coverage without regard to the specific benefits for which the individual had coverage during the period.

SECTION 33. 632.746 (6) of the statutes, as created by 1997 Wisconsin Act 27, is amended to read:

632.746 **(6)** ~~An~~ A self–insured health plan or an insurer offering a group health benefit plan shall permit an employe who is not enrolled but who is eligible for coverage under the terms of the self–insured health plan or group health benefit plan, or a participant's or employe's dependent who is not enrolled but who is eligible for coverage under the terms of the self–insured health plan or group health benefit plan, to enroll for coverage under the terms of the plan if all of the following apply:

(a) The employe or dependent was covered under a self–insured health plan or group health plan or had health insurance coverage at the time coverage was previously offered to the employe or dependent.

(b) The employe or participant stated in writing at the time coverage was previously offered that coverage under a self–insured health plan or group health plan or health insurance coverage was the reason for declining enrollment under the self–insured health plan or insurer's group health benefit plan. This paragraph applies only if the self–insured health plan or insurer required such a statement at

the time coverage was previously offered and provided the employe or participant, at the time coverage was previously offered, with notice of the requirement and the consequences of the requirement.

(c) The employe or dependent is currently covered under the self–insured health plan, group health plan or health insurance or, under the terms of the self–insured health plan or group health benefit plan, the employe or participant requests enrollment no later than 30 days after the date on which the coverage under par. (a) is exhausted or terminated.

SECTION 34. 632.746 (7) (a) (intro.), (b) (intro.) and 1. and (c) 1., of the statutes, as created by 1997 Wisconsin Act 27, are amended to read:

632.746 **(7)** (a) (intro.) If par. (b) applies, a self–insured health plan or an insurer offering a group health benefit plan shall provide for a special enrollment period during which any of the following may occur:

(b) (intro.) ~~An~~ A self–insured health plan or an insurer under par. (a) is required to provide for a special enrollment period if all of the following apply:

1. The self–insured health plan or group health benefit plan makes coverage available for dependents of participants under the plan.

(c) 1. The date dependent coverage is made available under the self–insured health plan or group health benefit plan.

SECTION 35. 632.7465 of the statutes is created to read:

632.7465 Guaranteed issue for group health benefit plans. (1) In this section, "employer" means, with respect to a calendar year and a plan year, an employer that employed an average of at least 2 but not more than 100 employes on business days during the preceding calendar year, or that is reasonably expected to employ an average of at least 2 but not more than 100 employes on business days

during the current calendar year if the employer was not in existence during the preceding calendar year, and that employs at least 2 employes on the first day of the plan year.

(2) Except as provided in subs. (4) and (5), an insurer shall provide coverage under a group health benefit plan to an employer and to all of the employer's eligible employes and their dependents, regardless of health condition or claims experience, if all of the following apply:

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

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

(c) The employer agrees to comply with all other provisions of the group health benefit plan that apply generally to a policyholder or an insured without regard to health condition or claims experience.

(3) An insurer that provides coverage under sub. (2) may impose payment security provisions that are reasonably related to the risk covered.

(4) (a) An insurer that is otherwise required to provide coverage under sub. (2) may refuse to issue a group health benefit plan to an employer if all of the individuals in the employer group that are to be covered under the group health benefit plan may be covered under one individual health benefit plan providing family coverage.

(b) Subsection (2) does not require an insurer to issue coverage that the insurer is not authorized to issue under its bylaws, charter or certificate of incorporation or authority.

(c) Subsection (2) does not require an insurer that provides coverage to an employer under a group health benefit plan to issue a different group health benefit

plan to the employer before the expiration of the agreed term of the group health benefit plan under which the employer has coverage.

(d) An insurer that offers health care coverage exclusively to a single category or limited categories of employers may, with prior approval of the commissioner, limit its compliance with sub. (2) to that single category or those limited categories of employers.

(e) The commissioner may exempt an insurer from the requirements of sub. (2) if the commissioner determines that it is in the public interest to exempt the insurer from the requirements under sub. (2) because the insurer is in financially hazardous condition.

(f) If an employer loses coverage under a group health benefit plan for failure to pay a premium when due, an insurer that is otherwise required to provide coverage under sub. (2) may refuse to issue a group health benefit plan to that employer during the 12–month period beginning on the day on which the employer lost coverage.

(g) An insurer that previously issued group health benefit plans but, prior to the effective date of this paragraph .... [revisor inserts date], discontinued offering such plans to small employers shall within 60 days after the effective date of this paragraph .... [revisor inserts date], again offer group health benefit plans to small employers or be subject to the requirements under s. 632.749 as if the insurer had elected to discontinue offering a group health benefit plan.

(5) (a) In this subsection, "high–risk individual" means an individual with a high–risk medical condition who has coverage under a group health benefit plan with a premium rate at the insurer's highest premium rate level.

(b) An insurer that is otherwise required to provide coverage under sub. (2) shall be exempt from the requirement under sub. (2) for the remainder of a calendar year after all of the following occur:

1. The number of high–risk individuals covered by the insurer at least equals the threshold level determined under par. (e) 3.

2. The insurer applies for exemption from the requirement under sub. (2) by certifying its qualification under subd. 1. to the commissioner and the commissioner, within 30 days after the insurer submits its certifying information, makes no objection and does not request additional information. If the commissioner does timely object or request additional information, the insurer shall be exempt from the requirements under sub. (2) 30 days after the commissioner objects or the insurer submits the additional information if the commissioner takes no further action.

(c) Whenever an insurer becomes exempt from the requirement under sub. (2) by satisfying the criteria under par. (b), the commissioner shall provide notice of that exemption to all insurers offering group health benefit plans to employers in this state and to all insurance agents listed under s. 628.11 by those insurers.

(d) An insurer that satisfies the criterion under par. (b) 1. is not required to apply for exemption from the requirement under sub. (2). An insurer that does not apply for exemption shall remain subject to the requirement under sub. (2).

(e) In consultation with the committee on risk adjustment, the commissioner shall promulgate rules for the operation of the risk adjustment mechanism under this subsection, including rules that specify at least all of the following:

1. What diagnostic conditions constitute high–risk medical conditions for purposes of the definition of a high–risk individual.

2. How to determine an insurer's highest premium rate level for purposes of the definition of a high–risk individual.

3. What percentage of an insurer's total enrollment under group health benefit plans issued by the insurer constitutes the threshold level for purposes of par. (b) 1.

SECTION 36. 632.747 (title) of the statutes is amended to read:

632.747 (title) **Guaranteed acceptance under group health benefit plans.**

SECTION 37. 632.748 (title) of the statutes, as created by 1997 Wisconsin Act 27, is amended to read:

632.748 Prohibiting discrimination under group health benefit plans.

SECTION 38. 632.748 (4) (c) of the statutes, as created by 1997 Wisconsin Act 27, is amended to read:

632.748 **(4)** (c) Provide an exception from, or limit, the rate regulation under s. ~~635.05~~ 632.7497.

SECTION 39. 632.749 (title) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

632.749 (title) **Contract termination and renewability for group health benefit plans.**

SECTION 40. 632.749 (2) (e) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

632.749 **(2)** (e) In the case of a group health benefit plan that the insurer offers through a network plan, there is no longer an enrollee under the plan who resides, lives or works in the service area of the insurer or in an area in which the insurer is authorized to do business ~~and, in the case of the small group market, the insurer would deny enrollment under the plan under s. 635.19 (2) (a) 1~~.

SECTION 41. 632.7491 of the statutes is created to read:

632.7491 Disclosure of rating factors and renewability provisions for group health benefit plans. (1) Before the sale of a group health benefit plan, an insurer shall disclose to an employer all of the following:

(a) The insurer's right to increase premium rates and any factors limiting the amount of increase.

(b) The extent to which benefit design characteristics and case characteristics affect premium rates.

(c) The extent to which rating factors and changes in benefit design benefit design characteristics and case characteristics affect changes in premium rates.

(d) The employer's renewability rights.

(e) As part of the insurer's solicitation and sales materials, the availability of the information under par. (f).

(f) Upon the request of the employer, the following information:

1. The provisions, if any, of the plan or policy relating to preexisting condition exclusions.

2. The benefits and premiums available under all health insurance coverage offered by the insurer for which the employer is qualified.

(2) Information required to be disclosed under this section shall be provided in a manner that is understandable to an employer and shall be sufficient to reasonably inform an employer of the employer's rights and obligations under the health insurance coverage.

(3) An insurer is not required under this section to disclose information that is proprietary or trade secret information under applicable law.

SECTION 42. 632.7492 of the statutes is created to read:

632.7492 Annual certification of compliance for group health benefit plans. (1) RECORDS. An insurer that issues group health benefit plans to employers, as defined in s. 632.7497 (1), shall maintain at its principal place of business complete and detailed records with respect to those group health benefit plans relating to its rating methods and practices and its renewal underwriting methods and practices, and shall make the records available to the commissioner upon request.

(2) CERTIFICATION. An insurer that issues group health benefit plans to employers, as defined in s. 632.7497 (1), shall file with the commissioner on or before May 1 annually an actuarial opinion by a member of the American Academy of Actuaries certifying all of the following with respect to those group health benefit plans:

(a) That the insurer is in compliance with the rate provisions of s. 632.7497.

(b) That the insurer's rating methods are based on generally accepted and sound actuarial principles, policies and procedures.

(c) That the opinion is based on the actuary's examination of the insurer's records and a review of the insurer's actuarial assumptions and statistical methods used in setting rates and procedures used in implementing rating plans.

SECTION 43. 632.7494 of the statutes is created to read:

632.7494 Preexisting conditions and portability for individual health benefit plans. (1) (a) An individual health benefit plan may not impose a preexisting condition exclusion with respect to a covered individual for losses incurred more than 12 months after the individual's enrollment date under the plan.

(b) An individual health benefit plan may not define a preexisting condition more restrictively than any of the following:

1. A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the 18 months immediately preceding the individual's enrollment date under the plan and for which the individual did not seek medical advice, diagnosis, care or treatment.

2. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the 18 months immediately preceding the individual's enrollment date under the plan.

(c) Notwithstanding pars. (a) and (b), an individual health benefit plan may not impose a preexisting condition exclusion relating to pregnancy as a preexisting condition.

(2) An individual health benefit plan shall waive any period applicable to a preexisting condition exclusion period with respect to particular services for the period that the individual was covered with respect to those services under creditable coverage, if the creditable coverage terminated not more than 31 days before the individual applied for coverage under the individual health benefit plan.

SECTION 44. 632.7497 of the statutes is created to read:

632.7497 Rate regulation for individual and group health benefit plans. (1) In this section, "employer" means, with respect to a calendar year and a plan year, an employer that employed an average of at least 2 but not more than 100 employes on business days during the preceding calendar year, or that is reasonably expected to employ an average of at least 2 but not more than 100 employes on business days during the current calendar year if the employer was not in existence during the preceding calendar year, and that employs at least 2 employes on the first day of the plan year.

(2) Notwithstanding ch. 625, the commissioner shall promulgate rules that do all of the following:

(a) Establish restrictions on premium rates that an insurer may charge an employer for coverage under a group health benefit plan such that the premium rates charged to employers with similar case characteristics for the same or similar benefit design characteristics do not vary from the midpoint rate for those employers by more than 30% of that midpoint rate.

(b) Establish restrictions on premium rates that an insurer may charge an individual for coverage under an individual health benefit plan such that the premium rates charged to individuals with similar case characteristics for the same or similar benefit design characteristics do not vary from the midpoint rate for those individuals by more than 35% of that midpoint rate.

(c) Establish restrictions on increases in premium rates that an insurer may charge an employer for coverage under a group health benefit plan such that:

1. The percentage increase in the premium rate for a new rating period does not exceed the sum of the following:

a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period.

b. An adjustment, not to exceed 15% per year for small employers or 25% per year for large employers, adjusted proportionally for rating periods of less than one year, for such rating factors as claims experience, health condition and duration of coverage, determined in accordance with the insurer's rate manual or rating procedures.

c. An adjustment for a change in case characteristics or in benefit design characteristics, determined in accordance with the insurer's rate manual or rating procedures.

2. The percentage increase in the premium rate for a new rating period for a group health benefit plan issued before the effective date of this subdivision .... [revisor inserts date], does not exceed the sum of subd. 1. a. and c., unless premium rates are in compliance with the rules promulgated under par. (a).

(d) Require the premium rate of a health benefit plan issued before the effective date of this paragraph .... [revisor inserts date], to comply with the rules promulgated under par. (a) or (b) no later than 2 years after the effective date of this paragraph .... [revisor inserts date].

(e) Define the terms necessary for compliance with this section.

(f) Ensure that employers are classified using objective criteria.

(g) Ensure that rating factors are applied objectively and consistently to small employers.

SECTION 45. 632.7498 of the statutes is created to read:

632.7498 Temporary suspension of rate regulation for individual and group health benefit plans. (1) In this section, "employer" has the meaning given in s. 632.7497 (1).

(2) The commissioner may suspend the operation of all or any part of s. 632.7497 with respect to one or more employers or one or more individuals for one or more rating periods upon the written request of an insurer and a finding by the commissioner that the suspension is necessary in light of the financial condition of the insurer or that the suspension would enhance the efficiency and fairness of the health insurance market.

SECTION 46. 632.7499 of the statutes is created to read:

632.7499 Fair marketing standards for group and individual health benefit plans. (1) Every insurer that provides coverage under a health benefit plan shall actively market such health benefit plan coverage. In addition to other marketing limitations that the commissioner may authorize by rule, an insurer may limit its marketing under this subsection to any of the following:

(a) Health benefit plans for employer groups of all sizes.

(b) Health benefit plans for individuals.

(2) (a) Except as provided in par. (b), an insurer or an intermediary may not, directly or indirectly, do any of the following:

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

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

(b) Paragraph (a) does not prohibit an insurer or an intermediary from providing an employer or an individual with information about an established geographic service area or a restricted network provision of the insurer.

(3) (a) Except as provided in par. (b), an insurer may not, directly or indirectly, enter into any contract, agreement or arrangement with an intermediary that provides for or results in compensation to the intermediary for the sale of a health benefit plan that varies according to the health condition, claims experience,

industry, occupation or geographic area of the employer, eligible employes, insured individual or dependents.

(b) Payment of compensation on the basis of percentage of premium is not a violation of par. (a) if the percentage does not vary based on the health condition, claims experience, industry, occupation or geographic area of the employer, eligible employes, insured individual or dependents.

(4) An insurer may not terminate, fail to renew or limit its contract or agreement of representation with an intermediary for any reason related to the health condition, claims experience, occupation or geographic area of the employers, eligible employes, insured individuals or dependents placed by the intermediary with the insurer.

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

(6) Denial by an insurer of an application for coverage under a health benefit plan shall be in writing and shall state the reason or reasons for the denial.

(7) A 3rd–party administrator that enters into a contract, agreement or other arrangement with an insurer to provide administrative, marketing or other services related to the offering of health benefit plans to employers or individuals in this state is subject to this section and ss. 632.745 to 632.7498 as if it were an insurer.

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

SECTION 47. 632.76 (2) (a) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

632.76 **(2)** (a) No claim for loss incurred or disability commencing after 2 years from the date of issue of the policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of loss. This paragraph does not apply to a ~~group~~ health benefit plan, as defined in s. 632.745 ~~(9)~~ (11), which is subject to s. 632.746 or 632.7494.

SECTION 48. 632.896 (4) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

632.896 (4) Preexisting conditions. Notwithstanding ss. 632.746, 632.7494 and 632.76 (2) (a), a disability insurance policy that is subject to sub. (2) and that is in effect when a court makes a final order granting adoption or when the child is placed for adoption may not exclude or limit coverage of a disease or physical condition of the child on the ground that the disease or physical condition existed before coverage is required to begin under sub. (3).

SECTION 49. Chapter 635 of the statutes, as affected by 1997 Wisconsin Act 27, is repealed.

SECTION 50. Nonstatutory provisions.

(1) RISK ADJUSTMENT COMMITTEE. The commissioner of insurance shall appoint a committee on risk adjustment under section 15.04 (1) (c) of the statutes, consisting of 5 to 8 members, to advise the commissioner on, and to assist the commissioner in developing rules for, the group risk adjustment mechanism under section 633.7465 (4) of the statutes, as created by this act. The commissioner shall appoint at least 5 representatives of insurers to be members of the committee.

(2) RISK ADJUSTMENT MECHANISM EMERGENCY RULE–MAKING AUTHORITY. Using the procedure under section 227.24 of the statutes, the commissioner of insurance may

promulgate rules under section 632.7465 (5) (e) of the statutes, as created by this act, for the period before the effective date of the permanent rules promulgated under section 632.7465 (5) (e) of the statutes, as created by this act, but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) and (3) of the statutes, the commissioner is not required to make a finding of emergency.

(3) EVALUATION OF MARKET REFORMS.

(a) The commissioner of insurance shall evaluate the effectiveness of the health insurance market reforms under sections 632.745 to 632.7499 of the statutes, as affected by this act, and under the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104–191, including the effectiveness of the reforms with respect to all of the following:

1. Accessibility of health insurance coverage, including such accessibility for persons who reside in rural areas of the state.

2. Availability of health insurance coverage for uninsured persons.

3. Affordability of health insurance coverage.

(b) The commissioner shall submit a report of the results of the evaluation and any recommendations to the legislature in the manner provided under section 13.172 (2) of the statutes no later than the first day of the 24th month beginning after publication.

SECTION 51. Initial applicability.

(1) Unless otherwise specified, this act first applies to all of the following:

(a) Except as provided in paragraphs (b) and (c), health benefit plans that are issued or renewed, and self–insured health plans that are established, extended, modified or renewed, on the effective date of this paragraph.

(b) Health benefit plans covering employes who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified or renewed.

(c) Self–insured health plans covering employes who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified or renewed.

SECTION 52. Effective dates. This act takes effect on the first day of the 7th month beginning after publication, except as follows:

(1) SECTION 50 (1) and (2) of this act takes effect on the day after publication.

(END)