



1995 SENATE BILL 201

May 16, 1995 - Introduced by Senators ROSENZWEIG, SCHULTZ, BUETTNER, A. LASEE, DARLING, PLEWA and RUDE, cosponsored by Representatives UNDERHEIM, ALBERS, BRANCEL, OURADA, HANSON, JOHNSRUD, GROBSCHMIDT, GOETSCH, HANDRICK, DUFF, KREIBICH, POWERS, ZUKOWSKI, HUBER, SPRINGER and BOYLE. Referred to Committee on Insurance.

1 **AN ACT to repeal** 15.735 (1), 635.02 (1), 635.02 (4m), 635.02 (5), 635.02 (6), 635.02
2 (7) (b), 635.02 (8), 635.09, 635.17 (1) (b) 3. and 635.23 (3); **to renumber and**
3 **amend** 635.17 (1) (a) 1., 635.17 (1) (a) 2. and 635.18 (1); **to consolidate,**
4 **renumber and amend** 635.02 (7) (intro.) and (a); **to amend** 40.03 (6) (a) 2.,
5 111.70 (1) (a), 185.983 (1g), 625.12 (2), 628.34 (3), 628.36 (2) (b) 5., 632.70,
6 632.897 (2) (d), 632.897 (9) (c), chapter 635 (title), 635.02 (1c), 635.02 (2), 635.02
7 (3f), 635.02 (3j), 635.02 (3m), 635.02 (6m), 635.07 (1) (intro.), (b), (d) and (e),
8 635.07 (2), 635.07 (3), 635.11 (intro.), (1) and (4), 635.13 (1), 635.13 (2), 635.17
9 (title), 635.17 (1) (a) (intro.), 635.17 (1) (a) 3., 635.17 (1) (b) 1. and 2., 635.17 (2),
10 635.17 (3), 635.18 (2), 635.18 (3), 635.18 (4), 635.18 (5), 635.18 (6), 635.18 (7),
11 635.18 (8), 635.20 (1), 635.20 (2), 635.20 (11), 635.21, 635.23 (title) and (1)
12 (intro.), 635.23 (1) (a), (d), (dp), (dr) and (e) (intro.), 1., 2. and 3., 635.23 (1m),
13 635.23 (1r), 635.23 (2), 635.23 (4) and (5), 635.25 (title), 635.25 (1) (a) (intro.),
14 635.25 (1) (a) 2., 635.25 (1) (b), 635.25 (1m), 635.25 (2), 635.254, 635.26 (1),
15 635.26 (1m), 635.26 (1s), 635.26 (4), 635.272 (1), 635.28 and 635.29; **to repeal**
16 **and recreate** 635.01, 635.02 (3), 635.05, 635.13 (1), 635.15 and 635.20 (13); and
17 **to create** 15.07 (1) (b) 21., 15.735 (3), 40.02 (48g), 40.03 (6) (a) 3., 111.70 (4) (m),

1 153.07 (4), 600.03 (40m), 601.424, 632.727, 632.83, 635.02 (1r), 635.02 (3h),
2 635.02 (4g), 635.02 (5m) (d), 635.03, 635.06, 635.07 (1) (f), 635.17 (1) (a) 1. b.,
3 635.17 (1) (a) 2. b., 635.17 (1) (ac), 635.17 (1) (am), 635.17 (1) (ar), 635.17 (1) (c),
4 635.18 (1) (a) to (c), 635.18 (9), (9m) and (10), 635.20 (1b) and 635.26 (5) of the
5 statutes; **relating to:** expanding the small employer insurance board and
6 renaming it the comprehensive health care board; modified community rating,
7 fair market standards, portability, preexisting condition exclusions and
8 guaranteed issue for individual and certain group health benefit plans;
9 allowing the group insurance board to contract with purchasing coalitions; and
10 granting rule-making authority.

Analysis by the Legislative Reference Bureau

HEALTH INSURANCE MARKET REFORM

Scope of reform

This bill imposes a number of insurance market reform requirements on insurers with respect to individual health benefit plans and group health benefit plans sold to employers with 2 to 100 employees with a normal work week of 30 or more hours. A health benefit plan is defined in the bill as any hospital or medical policy or certificate, including a conversion health insurance policy, but excluding such insurance policies as dental, vision, long-term care, medicare supplement, medicare replacement, worker's compensation, specified disease, health insurance risk-sharing plan (HIRSP) and automobile medical payment insurance policies.

Community rating

All health benefit plans subject to the market reform requirements must be community rated. The community rates, however, may be modified by the insured's age, gender, geographic area and tobacco use and by whether the insured's coverage is single or family. An insured's "geographic area" for this purpose may not be less than an entire county. The commissioner of insurance (commissioner) must by rule prescribe rate bands for the modifications and may also by rule prescribe rate restrictions that provide for a transition to the modified community rates. Additionally, an insurer may provide discounts for insured individuals for healthy lifestyle choices.

Guaranteed issue

With some exceptions, an insurer that has in force a health benefit plan that is subject to the market reform requirements must issue a group health benefit plan

to an employer that agrees to pay the premium and comply with all other plan provisions, and to all of the employer's employees with a normal work week of 30 or more hours, including employees who were excluded from coverage previously and employees who become eligible for coverage after the commencement of the employer's coverage, without regard to health condition or claims experience. Such an insurer is also required to issue an individual health benefit plan to an individual who agrees to pay the premium and comply with all other plan provisions, without regard to health condition or claims experience. An insurer, however, may limit its issuance of health benefit plans to group plans, and related individual conversion policies, for employers with 2 to 25 employees, to group plans, and related individual conversion policies, for employers with 26 to 100 employees or to individual plans.

Preexisting conditions and portability

Under current law a group health benefit plan issued to an employer with 2 to 25 employees may not exclude or limit benefits on account of a preexisting condition for more than 12 months after the commencement of coverage and may not define a preexisting condition more restrictively than a pregnancy existing on the effective date of coverage or a condition for which the insured sought or should have sought medical care during the 6 months immediately preceding coverage. Additionally, such a plan must waive any period applicable to a preexisting condition exclusion or limitation that was satisfied under another plan under which the insured had coverage to a date not less than 30 days before the effective date of coverage under the new plan.

Under the bill, except for a conversion health insurance policy, which under current law may not impose any preexisting condition limitations or exclusions, a group or an individual health benefit plan subject to the market reform requirements may not exclude or limit benefits on account of a preexisting condition for more than 12 months. A group or individual health benefit plan may not define a preexisting condition more restrictively than a pregnancy existing on the effective date of coverage, except that coverage may not be excluded for any covered prenatal care expenses or for other covered expenses that exceed a deductible amount prescribed by the commissioner by rule. The deductibles prescribed by the commissioner may not exceed \$5,000 and must be based on a sliding scale related to the stage of the pregnancy on the effective date of coverage. Additionally, a group health benefit plan may not define a preexisting condition more restrictively than a condition for which the insured sought or should have sought medical care during the 6 months immediately preceding coverage, and an individual plan may not define a preexisting condition more restrictively than a condition for which the insured sought or should have sought medical care during the 12 months immediately preceding coverage. An individual who has been a resident for at least 6 months or an employee who has satisfied any necessary waiting period may obtain coverage under a group or individual health benefit plan without any preexisting condition exclusion or limitation if the individual or employee applies for coverage within 30 days after the later of the date on which the individual or employee becomes 18 years old or the date on which the individual's or employee's coverage under a health benefit plan as a dependent ceases or during a biennial 30-day open enrollment period

specified by the commissioner by rule. Both group and individual health benefit plans subject to the market reform requirements must waive any period applicable to a preexisting condition exclusion or limitation that was satisfied under another plan, including HIRSP, under which the insured had coverage if that coverage terminated 60 days or less before the effective date of coverage under the new plan.

Contract renewability and fair marketing standards

A health benefit plan that is subject to the market reform requirements may not be canceled before the expiration of the agreed term, and must be renewed at the option of the policyholder, except for such reasons as failure to pay a premium when due or fraud or misrepresentation. An insurer may elect not to renew a health benefit plan only if the insurer thereafter ceases to issue or renew any health benefit plans for a minimum of 5 years.

Insurers that offer health benefit plans that are subject to the requirements must actively market such health benefit plans and are prohibited from such marketing practices as discouraging an employer or individual from applying for coverage, or encouraging an employer or individual to seek coverage from a different insurer, for reasons related to health condition, claims experience or other characteristics of the employer or individual.

These contract renewability and fair marketing provisions apply under current law to group health benefit plans that are issued to an employer with 2 to 25 employees.

Comprehensive health care board and reinsurance

The bill creates a comprehensive health care board (board) as an expansion of the small employer insurance board. The board consists of the commissioner, the secretary of employee trust funds, 3 members of the board on health care information who are elected by the board on health care information and the following members appointed for 3-year terms: 5 members who represent employers, 3 members who represent eligible employees, one member who represents a labor organization and 3 members who represent purchasing coalitions. (A purchasing coalition is a corporation or cooperative that purchases or arranges for the purchase of health care coverage or services for 2 or more employers and that is controlled by those employers.)

The bill repeals the small employer insurance board and the comprehensive health care board assumes the duties of the small employer insurance board with respect to administering the small employer health insurance plan under current law. In addition, the board is given additional duties to provide data or technical assistance to any purchasing coalition, develop quality outcomes measures, quality and practice pattern standards and health plan performance criteria, provide information on technology assessment to any purchasing coalition and recommend cost containment measures and provide assessments of health care needs to any purchasing coalition. The board must also submit proposed legislation for a reinsurance program for insurers that are subject to the market reform requirements. The reinsurance program must be optional, must allow an insurer to select among 3 different threshold amounts, must require the commissioner to pay 80% of claims above the threshold amount selected by an insurer and must provide

for a premium and assessment arrangement for funding a health reinsurance fund out of which the claims will be paid.

OTHER

Electronic claims

The bill requires every insurer that offers health insurance (called disability insurance in the statutes) to accept all claims electronically and to allow electronic access to eligibility and claims status information. Insurers must have this capability and use it beginning on January 1, 1997. Also beginning on that date, health care providers that have annual gross revenues of more than \$1,000,000 must be able to transmit health insurance claims electronically. All other health care providers must have and use this capability beginning on January 1, 1998.

Health insurance risk-sharing plan reports

The bill requires the commissioner to study the effects that the health insurance market reforms under the bill have on enrollment in, and other aspects of, HIRSP. Beginning on October 1, 1999, the commissioner must submit an annual report to the legislature on the effects.

Group insurance board

The bill authorizes the group insurance board to enter into contracts with purchasing coalitions to further the purposes of the health care plans for state employees.

For further information see the *state* fiscal estimate, which will be printed as an appendix to this bill.

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

1 **SECTION 1.** 15.07 (1) (b) 21. of the statutes is created to read:

2 15.07 (1) (b) 21. The members of the comprehensive health care board
3 appointed under s. 15.735 (3) (b) 1. to 4.

4 **SECTION 2.** 15.735 (1) of the statutes is repealed.

5 **SECTION 3.** 15.735 (3) of the statutes is created to read:

6 15.735 (3) COMPREHENSIVE HEALTH CARE BOARD. (a) In this subsection:

7 1. "Eligible employe" means an employe who works on a full-time basis and has
8 a normal work week of 30 or more hours. The term includes a sole proprietor, a
9 business owner, including the owner of a farm business, a partner of a partnership,
10 a member of a limited liability company and an independent contractor if the sole

1 proprietor, business owner, partner, member or independent contractor is included
2 as an employe under a health benefit plan of an employer, but the term does not
3 include an employe who works on a part-time, temporary or substitute basis.

4 2. "Employer" means any of the following:

5 a. An individual, firm, corporation, partnership, limited liability company or
6 association that is actively engaged in a business enterprise in this state, including
7 a farm business, and that employs in this state not more than 100 eligible employes.

8 b. A municipality, as defined in s. 16.70 (8), that employs not more than 100
9 eligible employes.

10 (b) There is created a comprehensive health care board that is attached to the
11 office of the commissioner of insurance under s. 15.03, consisting of the commissioner
12 of insurance or his or her designee, the secretary of employe trust funds or his or her
13 designee, 3 members of the board on health care information who are elected by the
14 board on health care information and the following members appointed for 3-year
15 terms:

16 1. Five members who represent employers.

17 2. Three members who represent eligible employes.

18 3. One member who represents a labor organization.

19 4. Three members who represent purchasing coalitions, as defined in s. 600.03
20 (40m).

21 (c) Notwithstanding s. 15.07 (2) (intro.), the commissioner of insurance shall
22 be a nonvoting member who shall serve permanently as chairperson of the board.

23 **SECTION 4.** 40.02 (48g) of the statutes is created to read:

24 40.02 (48g) "Purchasing coalition" has the meaning given in s. 600.03 (40m).

25 **SECTION 5.** 40.03 (6) (a) 2. of the statutes is amended to read:

1 40.03 (6) (a) 2. May, wholly or partially in lieu of subd. 1., on behalf of the state,
2 provide any group insurance plan on a self-insured basis in which case the group
3 insurance board shall approve a written description setting forth the terms and
4 conditions of the plan, and may contract directly with providers of hospital, medical
5 or ancillary services to provide insured employes with the benefits provided under
6 this chapter; or

7 **SECTION 6.** 40.03 (6) (a) 3. of the statutes is created to read:

8 40.03 (6) (a) 3. May, wholly or partially in lieu of subd. 1., on behalf of the state,
9 enter into a contract with one or more purchasing coalitions to further the purpose
10 of ss. 40.51 and 40.52.

11 **SECTION 7.** 111.70 (1) (a) of the statutes is amended to read:

12 111.70 (1) (a) "Collective bargaining" means the performance of the mutual
13 obligation of a municipal employer, through its officers and agents, and the
14 representatives of its employes, to meet and confer at reasonable times, in good faith,
15 with the intention of reaching an agreement, or to resolve questions arising under
16 such an agreement, with respect to wages, hours and conditions of employment, and
17 with respect to a requirement of the municipal employer for a municipal employe to
18 perform law enforcement and fire fighting services under s. 61.66, except as provided
19 in sub. (4) (m) and s. 40.81 (3) and except that a municipal employer shall not meet
20 and confer with respect to any proposal to diminish or abridge the rights guaranteed
21 to municipal employes under ch. 164. The duty to bargain, however, does not compel
22 either party to agree to a proposal or require the making of a concession. Collective
23 bargaining includes the reduction of any agreement reached to a written and signed
24 document. The employer shall not be required to bargain on subjects reserved to
25 management and direction of the governmental unit except insofar as the manner

1 of exercise of such functions affects the wages, hours and conditions of employment
2 of the employes. In creating this subchapter the legislature recognizes that the
3 public employer must exercise its powers and responsibilities to act for the
4 government and good order of the municipality, its commercial benefit and the
5 health, safety and welfare of the public to assure orderly operations and functions
6 within its jurisdiction, subject to those rights secured to public employes by the
7 constitutions of this state and of the United States and by this subchapter.

8 **SECTION 8.** 111.70 (4) (m) of the statutes is created to read:

9 111.70 (4) (m) *Health insurance market reform.* A municipal employer that is
10 an employer under the definition specified in s. 635.02 (3h) (b) is prohibited from
11 bargaining collectively with respect to the health insurance requirements under
12 subch. I of ch. 635.

13 **SECTION 9.** 153.07 (4) of the statutes is created to read:

14 153.07 (4) The board shall elect 3 members to serve on the comprehensive
15 health care board.

16 **SECTION 10.** 185.983 (1g) of the statutes is amended to read:

17 185.983 (1g) A cooperative association that is a small employer insurer, as
18 defined in s. ~~635.02-(8)~~ 635.20 (13), is subject to the health insurance mandates, as
19 defined in s. 601.423 (1), to the same extent as any other small employer insurer, as
20 defined in s. ~~635.02-(8)~~ 635.20 (13).

21 **SECTION 11.** 600.03 (40m) of the statutes is created to read:

22 600.03 (40m) "Purchasing coalition" means a corporation or cooperative that
23 purchases or arranges for the purchase of health care coverage or services for 2 or
24 more employers and that is controlled by those employers.

25 **SECTION 12.** 601.424 of the statutes is created to read:

1 **601.424 Reports on market reform impact on the health insurance**
2 **risk-sharing plan.** The commissioner shall study the effects of the health
3 insurance market reforms under ch. 635 on enrollment in, and other aspects of, the
4 health insurance risk-sharing plan under subch. II of ch. 619. The commissioner
5 shall annually submit a report on the effects and any recommendations to the
6 legislature under s. 13.172 (2) commencing on October 1, 1999.

7 **SECTION 13.** 625.12 (2) of the statutes is amended to read:

8 625.12 (2) CLASSIFICATION. ~~Risks~~ Subject to s. 635.05 and any rules
9 promulgated under s. 635.06, risks may be classified in any reasonable way for the
10 establishment of rates and minimum premiums, except that no classifications may
11 be based on race, color, creed or national origin, and classifications in automobile
12 insurance may not be based on physical condition or developmental disability as
13 defined in s. 51.01 (5). Subject to ~~s. ss. 632.365 and 635.05 and any rules promulgated~~
14 under s. 635.06, rates thus produced may be modified for individual risks in
15 accordance with rating plans or schedules that establish reasonable standards for
16 measuring probable variations in hazards, expenses, or both. Rates may also be
17 modified for individual risks under s. 625.13 (2).

18 **SECTION 14.** 628.34 (3) of the statutes is amended to read:

19 628.34 (3) UNFAIR DISCRIMINATION. (a) No insurer may unfairly discriminate
20 among policyholders by charging different premiums or by offering different terms
21 of coverage except on the basis of classifications related to the nature and the degree
22 of the risk covered or the expenses involved, subject to ~~s. ss. 632.365 and 635.05 and~~
23 any rules promulgated under s. 635.06. Rates are not unfairly discriminatory if they
24 are averaged broadly among persons insured under a group, blanket or franchise

1 policy, and terms are not unfairly discriminatory merely because they are more
2 favorable than in a similar individual policy.

3 (b) No insurer may refuse to insure or refuse to continue to insure, or limit the
4 amount, extent or kind of coverage available to an individual, or charge an individual
5 a different rate for the same coverage because of a mental or physical disability
6 except when the refusal, limitation or rate differential is based on either sound
7 actuarial principles supported by reliable data or actual or reasonably anticipated
8 experience, subject to ss. 635.05, 635.07 and 635.15 and any rules promulgated
9 under s. 635.06.

10 **SECTION 15.** 628.36 (2) (b) 5. of the statutes is amended to read:

11 628.36 (2) (b) 5. Except for the small employer health insurance plan under
12 subch. II of ch. 635 to the extent determined by the small employer insurance board
13 under s. 635.23 (1) (b), 1993 stats., or the comprehensive health care board under s.
14 635.23 (1) (b), all health care plans, including health maintenance organizations,
15 limited service health organizations and preferred provider plans are subject to s.
16 632.87 (3).

17 **SECTION 16.** 632.70 of the statutes is amended to read:

18 **632.70 Exemption for plan under ch. 635.** The health insurance mandates,
19 as defined in s. 601.423 (1), that are provided under this subchapter apply to the
20 small employer health insurance plan under subch. II of ch. 635 only to the extent
21 determined by the small employer insurance board under s. 635.23 (1) (b), 1993
22 stats., or the comprehensive health care board under s. 635.23 (1) (b).

23 **SECTION 17.** 632.727 of the statutes is created to read:

24 **632.727 Electronic claims capability. (1) DEFINITION.** In this section,
25 “health care provider” has the meaning given in s. 146.81 (1) (a) to (m).

1 **(2) INSURERS.** Beginning on January 1, 1997, every insurer that offers disability
2 insurance must have and use the capability to accept all claims electronically and to
3 allow electronic access to information on eligibility, claim status and remittance
4 advice.

5 **(3) HEALTH CARE PROVIDERS.** (a) Beginning on January 1, 1997, every health
6 care provider that has annual gross revenues of more than \$1,000,000 must have and
7 use the capability to electronically transmit disability insurance claims information.

8 (b) Beginning on January 1, 1998, every health care provider not specified in
9 par. (a) must have and use the capability to electronically transmit disability
10 insurance claims information.

11 **SECTION 18.** 632.83 of the statutes is created to read:

12 **632.83 Regulation of certain related policies.** The commissioner may, by
13 rule, prescribe standards for specified disease policies, hospital indemnity policies,
14 as defined in s. 632.895 (1) (c), or limited benefit health policies, including prohibiting
15 certain specified types of products, prescribing minimum coverage and establishing
16 marketing or suitability standards.

17 **SECTION 19.** 632.897 (2) (d) of the statutes is amended to read:

18 **632.897 (2) (d)** If the employer is notified to terminate the coverage for any of
19 the reasons provided under par. (b), the employer shall provide the terminated
20 insured written notification of the right to continue group coverage or convert to
21 individual coverage and the payment amounts required for either continued or
22 converted coverage including the manner, place and time in which the payments
23 shall be made. This notice shall be given not more than 5 days after the employer
24 receives notice to terminate coverage. The payment amount for continued group
25 coverage may not exceed the group rate in effect for a group member, including an

1 employer's contribution, if any, for a group policy as defined in sub. (1) (c) 1. or 1m,
2 or the equivalent value of the monthly contribution of a group member to a group
3 policy as defined in sub. (1) (c) 2. or the equivalent value of the monthly premium for
4 franchise insurance as defined in sub. (1) (c) 3. The premium for converted coverage
5 shall be determined in accordance with the insurer's table of premium rates
6 applicable to ~~the age and class of risks of~~ each person to be covered under that policy
7 and to the type and amount of coverage provided, subject to s. 635.05 and any rules
8 promulgated under s. 635.06. The notice may be sent to the terminated insured's
9 home address as shown on the records of the employer.

10 **SECTION 20.** 632.897 (9) (c) of the statutes is amended to read:

11 632.897 (9) (c) When the insurer is notified that the coverage of a spouse may
12 be terminated because of a divorce or annulment, the insurer shall provide the
13 former spouse written notification of the right to obtain individual coverage under
14 sub. (4), the premium amounts required and the manner, place and time in which
15 premiums may be paid. This notice shall be given not less than 30 days before the
16 former spouse's coverage would otherwise terminate. The premium shall be
17 determined in accordance with the insurer's table of premium rates applicable to ~~the~~
18 ~~age and class of risk of~~ every person to be covered and to the type and amount of
19 coverage provided, subject to s. 635.05 and any rules promulgated under s. 635.06.
20 If the former spouse tenders the first monthly premium to the insurer within 30 days
21 after the notice provided by this paragraph, sub. (4) shall apply and the former
22 spouse shall receive individual coverage commencing immediately upon termination
23 of his or her coverage under the insured's policy.

24 **SECTION 21.** Chapter 635 (title) of the statutes is amended to read:

CHAPTER 635**SMALL EMPLOYER REGULATION****OF HEALTH INSURANCE**

SECTION 22. 635.01 of the statutes is repealed and recreated to read:

635.01 Scope. (1) This subchapter applies to all of the following:

(a) Group health benefit plans, and insurers with respect to group health benefit plans, that are written on risks or operations in this state and that provide coverage for eligible employees of an employer.

(b) Individual health benefit plans, and insurers with respect to individual health benefit plans, that are issued or renewed to a policyholder who is a resident of this state and who was a resident of this state when the policy was first issued.

(2) The provisions of this subchapter that apply to individual health benefit plans apply to certificates issued under a group health benefit plan as if the certificates were individual health benefit plans if the group health benefit plan certificates are marketed to individuals.

SECTION 23. 635.02 (1) of the statutes is repealed.

SECTION 24. 635.02 (1c) of the statutes is amended to read:

635.02 **(1c)** "Basic health benefit plan" means the a small employer health insurance plan under subch. II.

SECTION 25. 635.02 (1r) of the statutes is created to read:

635.02 **(1r)** "Board" means the comprehensive health care board.

SECTION 26. 635.02 (2) of the statutes is amended to read:

635.02 **(2)** "Case characteristics" means the demographic, actuarially based characteristics of the employees of a small employer, and the employer, if covered members of a group or of an individual, such as age, sex gender, geographic location

1 area and occupation, used by a ~~small employer~~ an insurer to determine premium
2 rates for a ~~small employer~~ health benefit plan. “Case characteristics” does not
3 include loss or claim history, health status condition, duration of coverage or other
4 factors related to ~~claim~~ claims experience.

5 **SECTION 27.** 635.02 (3) of the statutes is repealed and recreated to read:

6 635.02 (3) “Community rate” means a uniform rate determined in such a
7 manner that all insured individuals with the same level of coverage and plan design
8 pay the same rate for that coverage, without regard to case characteristics or to loss
9 or claim history, health condition, duration of coverage or other factors related to
10 claims experience.

11 **SECTION 28.** 635.02 (3f) of the statutes is amended to read:

12 635.02 (3f) “Eligible employe” means an employe who works on a full-time
13 basis and has a normal work week of 30 or more hours. The term includes a sole
14 proprietor, a business owner, including the owner of a farm business, a partner of a
15 partnership, a member of a limited liability company and an independent contractor
16 if the sole proprietor, business owner, partner, member or independent contractor is
17 included as an employe under a health benefit plan of a ~~small~~ an employe, but the
18 term does not include an employe who works on a part-time, temporary or substitute
19 basis.

20 **SECTION 29.** 635.02 (3h) of the statutes is created to read:

21 635.02 (3h) “Employer” means any of the following:

22 (a) An individual, firm, corporation, partnership, limited liability company or
23 association that is actively engaged in a business enterprise in this state, including
24 a farm business, and that employs in this state not fewer than 2 nor more than 100
25 eligible employes. In determining the number of eligible employes, employers that

1 are affiliated, or that are eligible to file a combined tax return for purposes of state
2 taxation, shall be considered one employer.

3 (b) A municipality, as defined in s. 16.70 (8), that employs not fewer than 2 nor
4 more than 100 eligible employees.

5 **SECTION 30.** 635.02 (3j) of the statutes is amended to read:

6 635.02 (3j) “Established geographic service area” means a geographic area
7 within which a ~~small employer~~ an insurer provides coverage and that has been
8 approved by the commissioner.

9 **SECTION 31.** 635.02 (3m) of the statutes is amended to read:

10 635.02 (3m) “Health benefit plan” means any hospital or medical policy or
11 certificate, and includes a conversion health insurance policy. “Health benefit plan”
12 does not include accident-only, credit, dental, vision, medicare supplement,
13 medicare replacement, long-term care, or disability income insurance, coverage
14 issued as a supplement to liability insurance, worker’s compensation or similar
15 insurance, automobile medical payment insurance, specified disease policies,
16 hospital indemnity policies, as defined in s. 632.895 (1) (c), policies or certificates
17 issued under the health insurance risk-sharing plan or an alternative plan under
18 subch. II of ch. 619 or other insurance exempted by rule of the commissioner.

19 **SECTION 32.** 635.02 (4g) of the statutes is created to read:

20 635.02 (4g) “Insurer” means an insurer that is authorized to do business in this
21 state, in one or more lines of insurance that includes health insurance, and that
22 offers group health benefit plans covering eligible employees of one or more employers
23 in this state, or that sells individual health benefit plans to individuals who are
24 residents of this state. The term includes a health maintenance organization, as
25 defined in s. 609.01 (2), a preferred provider plan, as defined in s. 609.01 (4), and an

1 insurer operating as a cooperative association organized under ss. 185.981 to
2 185.985, but does not include a limited service health organization, as defined in s.
3 609.01 (3).

4 **SECTION 33.** 635.02 (4m) of the statutes is repealed.

5 **SECTION 34.** 635.02 (5) of the statutes is repealed.

6 **SECTION 35.** 635.02 (5m) (d) of the statutes is created to read:

7 635.02 (5m) (d) The health insurance risk-sharing plan or an alternative plan
8 under subch. II of ch. 619.

9 **SECTION 36.** 635.02 (6) of the statutes is repealed.

10 **SECTION 37.** 635.02 (6m) of the statutes is amended to read:

11 635.02 (6m) "Restricted network provision" means a provision of a health
12 benefit plan that conditions the payment of benefits, in whole or in part, on obtaining
13 services or articles from health care providers that have contracted with the ~~small~~
14 ~~employer~~ insurer to provide health care services or articles to covered individuals.

15 **SECTION 38.** 635.02 (7) (intro.) and (a) of the statutes are consolidated,
16 renumbered 635.02 (7) and amended to read:

17 635.02 (7) "Small employer" means ~~any of the following: (a) An individual,~~
18 ~~firm, corporation, partnership, limited liability company or association that is~~
19 ~~actively engaged in a business enterprise in this state, including a farm business,~~
20 ~~and an employer that employs in this state not fewer than 2 nor more than 25 eligible~~
21 ~~employees. In determining the number of eligible employees, employers that are~~
22 ~~affiliated, or that are eligible to file a combined tax return for purposes of state~~
23 ~~taxation, shall be considered one employer.~~

24 **SECTION 39.** 635.02 (7) (b) of the statutes is repealed.

25 **SECTION 40.** 635.02 (8) of the statutes is repealed.

1 **SECTION 41.** 635.03 of the statutes is created to read:

2 **635.03 Duties of the board.** In addition to any other duties specifically
3 required under this subchapter, the board shall do all of the following:

4 (1) Perform the duties required under subch. II.

5 (2) Provide data or technical assistance to any purchasing coalition.

6 (3) Develop quality outcomes measures, quality and practice pattern
7 standards and health plan performance criteria.

8 (4) Provide information on technology assessment to any purchasing coalition.

9 (5) Recommend cost containment measures and provide assessments of health
10 care needs to any purchasing coalition.

11 **SECTION 42.** 635.05 of the statutes is repealed and recreated to read:

12 **635.05 Community rating.** (1) Except as provided in subs. (2) and (4), an
13 insurer shall charge a community rate for coverage under a health benefit plan that
14 is subject to this subchapter and that is issued or renewed on or after the effective
15 date of this subsection [revisor inserts date].

16 (2) Subject to rate bands prescribed by the commissioner by rule, the
17 community rate under sub. (1) may be modified by taking into account the following
18 factors:

19 (a) The insured's age.

20 (b) The insured's gender.

21 (c) The insured's geographic area, which may not include less than an entire
22 county.

23 (d) The insured's tobacco use.

24 (e) Whether the insured's coverage is single coverage or a type of family
25 coverage.

1 **(3)** For each of the following factors, the rate bands prescribed by the
2 commissioner by rule may not restrict the ratio of the highest variance to the lowest
3 variance to a ratio that is less than the ratio shown after each factor:

4 (a) For age, a ratio of 2.5.

5 (b) For gender, a ratio of 1.2.

6 (c) For geographic area, a ratio of 1.2.

7 **(4)** An insurer may provide a rate discount for healthy lifestyle choices on the
8 part of an insured individual that, given the individual's health condition, tend to
9 reduce the risk of loss.

10 **SECTION 43.** 635.06 of the statutes is created to read:

11 **635.06 Transition by rule.** Notwithstanding s. 635.05 (1) and (2), the
12 commissioner may promulgate rules that permit an insurer to vary from the
13 community rate required under s. 635.05 (1) and modified under s. 635.05 (2) within
14 restrictions provided in the rules. The restrictions provided in the rules shall be
15 reasonably designed to provide for an orderly transition to the community rates
16 required under s. 635.05 (1) and modified under s. 635.05 (2) for all health benefit
17 plans subject to this subchapter by no later than the first day of the 12th month
18 beginning after the effective date of this section [revisor inserts date].

19 **SECTION 44.** 635.07 (1) (intro.), (b), (d) and (e) of the statutes are amended to
20 read:

21 635.07 **(1)** (intro.) Notwithstanding s. 631.36 (2) to (4m), a health benefit plan
22 ~~or policy~~ subject to this subchapter may not be canceled by an insurer before the
23 expiration of the agreed term, and shall be renewable to the ~~employer and all~~
24 ~~employees~~ policyholder and all insureds and dependents eligible under the terms of

1 the health benefit plan or policy at the expiration of the agreed term at the option of
2 the ~~small employer~~ policyholder, except for any of the following reasons:

3 (b) Fraud or misrepresentation by the ~~small employer~~ policyholder, or, with
4 respect to coverage for an insured individual, fraud or misrepresentation by ~~the~~ that
5 insured individual.

6 (d) The number of individuals covered under the health benefit plan or policy
7 is less than the number required by the health benefit plan or policy.

8 (e) The ~~small~~ employer is no longer actively engaged in a business enterprise.

9 **SECTION 45.** 635.07 (1) (f) of the statutes is created to read:

10 635.07 (1) (f) The health benefit plan is an individual policy and the
11 commissioner permits cancellation or nonrenewal of such a policy by rule.

12 **SECTION 46.** 635.07 (2) of the statutes is amended to read:

13 635.07 (2) Notwithstanding sub. (1), a ~~small employer~~ an insurer may elect not
14 to renew a health insurance benefit plan or policy subject to this subchapter if the
15 ~~small employer~~ insurer complies with all of the following:

16 (a) The ~~small employer~~ insurer ceases to renew all other health benefit plans
17 or policies subject to this subchapter ~~that are issued to all other small employers in~~
18 ~~the same class of business~~.

19 (b) The ~~small employer~~ insurer provides notice to all affected ~~small employers~~
20 policyholders and to the commissioner in each state in which an affected insured
21 individual resides not later than one year before termination of coverage.

22 (c) The ~~small employer~~ insurer does not ~~establish a new class of business~~ issue
23 a health benefit plan subject to this subchapter earlier than 5 years after the
24 nonrenewal of the health benefit plans or policies.

1 (d) ~~The small employer insurer~~ does not transfer or otherwise provide coverage
2 to a ~~small employer~~ policyholder from the nonrenewed class of business unless the
3 ~~small employer insurer~~ offers to transfer or provide coverage to all affected ~~small~~
4 ~~employers~~ policyholders from the nonrenewed class of business without regard to
5 case characteristics, ~~claim~~ claims experience, health ~~status~~ condition or duration of
6 coverage.

7 **SECTION 47.** 635.07 (3) of the statutes is amended to read:

8 635.07 (3) This section does not apply to a health benefit plan ~~or policy~~ subject
9 to this subchapter if the ~~small employer insurer~~ that issued the ~~policy~~ health benefit
10 plan is in liquidation.

11 **SECTION 48.** 635.09 of the statutes is repealed.

12 **SECTION 49.** 635.11 (intro.), (1) and (4) of the statutes are amended to read:

13 **635.11 Disclosure of rating factors and renewability provisions.** (intro.)

14 Before the sale of a health benefit plan ~~or policy~~ subject to this subchapter, a ~~small~~
15 ~~employer~~ an insurer shall disclose to a ~~small employer~~ an applicant all of the
16 following:

17 (1) ~~The small employer insurer's~~ right to increase premium rates and the
18 factors limiting the amount of increase.

19 (4) ~~The small employer's~~ A policyholder's renewability rights.

20 **SECTION 50.** 635.13 (1) of the statutes is amended to read:

21 635.13 (1) RECORDS. A small employer insurer shall maintain at its principal
22 place of business complete and detailed records relating to its rating methods and
23 practices and its renewal underwriting methods and practices, and shall make the
24 records available to the commissioner ~~and the small employer insurance~~ or the board
25 upon request.

1 **SECTION 51.** 635.13 (1) of the statutes, as affected by 1995 Wisconsin Act ...
2 (this act), is repealed and recreated to read:

3 635.13 (1) RECORDS. An insurer shall maintain at its principal place of business
4 complete and detailed records relating to its rating methods and practices and its
5 renewal underwriting methods and practices, and shall make the records available
6 to the commissioner or the board upon request.

7 **SECTION 52.** 635.13 (2) of the statutes is amended to read:

8 635.13 (2) CERTIFICATION. ~~A small employer~~ An insurer shall file with the
9 commissioner on or before May 1 annually an actuarial opinion by a member of the
10 American academy of actuaries certifying all of the following:

11 (a) That the ~~small employer~~ insurer is in compliance with the rate provisions
12 of s. 635.05 and any rules promulgated under s. 635.06.

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

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

19 **SECTION 53.** 635.15 of the statutes is repealed and recreated to read:

20 **635.15 Guaranteed issue. (1) GROUP HEALTH BENEFIT PLANS.** (a) Except as
21 provided in sub. (3), an insurer shall provide coverage under a group health benefit
22 plan that is subject to this subchapter to an employer and to all of the employer's
23 eligible employees and their dependents, regardless of health condition or claims
24 experience, if all of the following apply:

1 1. The insurer has in force a health benefit plan that is subject to this
2 subchapter.

3 2. The employer agrees to pay the premium required for coverage under the
4 group health benefit plan.

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

8 (b) An insurer shall provide coverage under a group health benefit plan that
9 is subject to this subchapter to all of the following, regardless of health condition or
10 claims experience:

11 1. An eligible employe who becomes eligible for coverage after the
12 commencement of the employer's coverage, and the eligible employe's dependents.

13 2. An eligible employe who was excluded from coverage, including an eligible
14 employe with coverage under the health insurance risk-sharing plan or an
15 alternative plan under subch. II of ch. 619 on or before the effective date of this
16 subdivision [revisor inserts date], and the eligible employe's dependents.

17 3. An eligible employe's dependent who was excluded from coverage, including
18 an eligible employe's dependent with coverage under the health insurance
19 risk-sharing plan or an alternative plan under subch. II of ch. 619 on or before the
20 effective date of this subdivision [revisor inserts date].

21 **(2) INDIVIDUAL HEALTH BENEFIT PLANS.** Except as provided in sub. (3) and
22 notwithstanding s. 632.897 (4) (d), an insurer shall provide coverage under an
23 individual health benefit plan subject to this subchapter to an individual who is a
24 resident of this state, and to the individual's dependents, regardless of health
25 condition or claims experience, if all of the following apply:

1 (a) The insurer has in force a health benefit plan that is subject to this
2 subchapter.

3 (b) The individual agrees to pay the premium required for coverage under the
4 individual health benefit plan.

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

8 **(3) EXCEPTIONS TO GUARANTEED ISSUE.** (a) An insurer that is otherwise required
9 to provide coverage under sub. (1) may refuse to issue a group health benefit plan to
10 an employer if all of the individuals in the employer group that are to be covered
11 under the group health benefit plan may be covered under an individual health
12 benefit plan providing single or family coverage.

13 (b) An insurer that is otherwise required to provide coverage under sub. (2) may
14 refuse to provide coverage to an individual if the individual was excluded from
15 coverage under an employer's health benefit plan or self-funded health care plan for
16 reasons related to the individual's health condition.

17 (c) An insurer that is otherwise required to provide coverage under sub. (2) may
18 refuse to provide coverage to an individual if the individual waived coverage under
19 an employer's health benefit plan or self-funded health care plan for reasons related
20 to the individual's health condition.

21 (d) 1. In this paragraph, "municipal" means county, city, village, town or school
22 district.

23 2. Subsections (1) and (2) do not require an insurer to issue coverage that the
24 insurer is not authorized to issue under its bylaws, charter or certificate of
25 incorporation or authority if the insurer is authorized under its bylaws, charter or

1 certificate of incorporation or authority to issue coverage only to state or municipal
2 employes and former employes and their dependents.

3 (e) An insurer that offers health care coverage exclusively to a single category
4 or limited categories of employers may, with prior approval of the commissioner, limit
5 its compliance with subs. (1) and (2) to that single category or those limited categories
6 of employers.

7 (f) The commissioner may exempt an insurer from the requirements of sub. (1)
8 or (2) if the commissioner determines that any of the following applies:

9 1. It is inequitable to apply sub. (1) or (2) to the insurer due to its
10 disproportionate share of groups or individuals with high claims experience.

11 2. It is in the public interest to exempt the insurer from the requirements under
12 sub. (1) or (2) because the insurer is in financially hazardous condition.

13 (g) An insurer may limit its issuance of health benefit plans under subs. (1) and
14 (2) to any of the following:

15 1. Group health benefit plans, and related individual conversion policies, to
16 small employer groups.

17 2. Group health benefit plans, and related individual conversion policies, to
18 employer groups that are not small employer groups.

19 3. Individual health benefit plans.

20 **SECTION 54.** 635.17 (title) of the statutes is amended to read:

21 **635.17 (title) Coverage requirements for small employer health benefit**
22 **plans.**

23 **SECTION 55.** 635.17 (1) (a) (intro.) of the statutes is amended to read:

24 635.17 (1) (a) (intro.) A group or individual health benefit plan subject to this
25 subchapter may not deny, exclude or limit benefits for a covered individual for losses

1 incurred more than 12 months after the effective date of the individual's coverage
2 due to a preexisting condition. Such a health benefit plan may not define a
3 preexisting condition more restrictively than any of the following:

4 **SECTION 56.** 635.17 (1) (a) 1. of the statutes is renumbered 635.17 (1) (a) 1. a.
5 and amended to read:

6 635.17 (1) (a) 1. a. ~~A~~ With respect to a group health benefit plan, a condition
7 that would have caused an ordinarily prudent person to seek medical advice,
8 diagnosis, care or treatment during the 6 months immediately preceding the
9 effective date of coverage and for which the individual did not seek medical advice,
10 diagnosis, care or treatment.

11 **SECTION 57.** 635.17 (1) (a) 1. b. of the statutes is created to read:

12 635.17 (1) (a) 1. b. With respect to an individual health benefit plan, a condition
13 that would have caused an ordinarily prudent person to seek medical advice,
14 diagnosis, care or treatment during the 12 months immediately preceding the
15 effective date of coverage and for which the individual did not seek medical advice,
16 diagnosis, care or treatment.

17 **SECTION 58.** 635.17 (1) (a) 2. of the statutes is renumbered 635.17 (1) (a) 2. a.
18 and amended to read:

19 635.17 (1) (a) 2. a. ~~A~~ With respect to a group health benefit plan, a condition
20 for which medical advice, diagnosis, care or treatment was recommended or received
21 during the 6 months immediately preceding the effective date of coverage.

22 **SECTION 59.** 635.17 (1) (a) 2. b. of the statutes is created to read:

23 635.17 (1) (a) 2. b. With respect to an individual health benefit plan, a condition
24 for which medical advice, diagnosis, care or treatment was recommended or received
25 during the 12 months immediately preceding the effective date of coverage.

1 **SECTION 60.** 635.17 (1) (a) 3. of the statutes is amended to read:

2 635.17 (1) (a) 3. ~~A- With respect to a group or individual health benefit plan,~~
3 a pregnancy existing on the effective date of coverage, except that coverage may not
4 be excluded for any covered prenatal care expenses related to such a pregnancy or
5 for other covered expenses related to such a pregnancy that exceed the deductible
6 amount prescribed by the commissioner under par. (ac). Coverage not excluded may
7 be subject to any deductibles or copayments that apply generally under the policy.

8 **SECTION 61.** 635.17 (1) (ac) of the statutes is created to read:

9 635.17 (1) (ac) The commissioner shall by rule prescribe a separate deductible
10 for covered expenses related to a pregnancy existing on the effective date of coverage,
11 excluding covered prenatal care expenses. The rule shall provide for a sliding scale
12 deductible that does not exceed \$5,000 and that is determined on the basis of the
13 stage of the pregnancy on the effective date of the coverage, so that the deductible
14 is lower if coverage is obtained early in the pregnancy and higher if coverage is
15 obtained late in the pregnancy.

16 **SECTION 62.** 635.17 (1) (am) of the statutes is created to read:

17 635.17 (1) (am) Notwithstanding par. (a), an insurer shall provide coverage
18 under an individual or group health benefit plan subject to this subchapter to an
19 individual who has been a resident of this state for at least 6 months or to an eligible
20 employee who has satisfied any waiting period imposed by his or her employer, and
21 the dependents of the individual or eligible employee, without a preexisting condition
22 exclusion or limitation if the individual or eligible employee applies for coverage:

23 1. During a 30-day enrollment period specified by the commissioner by rule
24 under par. (ar).

25 2. Within 30 days after the later of the following:

- 1 a. The date on which the individual or employe becomes 18 years of age.
- 2 b. The date on which the individual's or employe's coverage as a dependent
- 3 under a health benefit plan ceases.

4 **SECTION 63.** 635.17 (1) (ar) of the statutes is created to read:

5 635.17 (1) (ar) The commissioner shall by rule specify a biennial 30-day

6 enrollment period during which an individual or an eligible employe, and the

7 dependents of the individual or eligible employe, may obtain coverage under par.

8 (am) under a group or individual health benefit plan subject to this subchapter

9 without any preexisting condition exclusion or limitation.

10 **SECTION 64.** 635.17 (1) (b) 1. and 2. of the statutes are amended to read:

11 635.17 (1) (b) 1. A group or individual health benefit plan subject to this

12 subchapter shall waive any period applicable to a preexisting condition exclusion or

13 limitation period with respect to particular services for the period that an individual

14 was previously covered by qualifying coverage that provided benefits with respect to

15 such services, if the qualifying coverage was ~~continuous to a date not less than 30~~

16 terminated not more than 60 days before the effective date of the new coverage.

17 2. Subdivision 1, does not prohibit the application of a waiting period to all new

18 enrollees under the a health benefit plan issued to an employer; however, a waiting

19 period may not be counted when determining whether the qualifying coverage was

20 ~~continuous to a date not less than 30~~ terminated not more than 60 days before the

21 effective date of the new coverage. For the purpose of subd. 1., the new coverage shall

22 be considered effective as of the date that it would be effective but for the waiting

23 period.

24 **SECTION 65.** 635.17 (1) (b) 3. of the statutes is repealed.

25 **SECTION 66.** 635.17 (1) (c) of the statutes is created to read:

1 635.17 (1) (c) This subsection does not apply to a conversion health insurance
2 policy, which is subject to s. 632.897 (4) (a).

3 **SECTION 67.** 635.17 (2) of the statutes is amended to read:

4 635.17 (2) MINIMUM PARTICIPATION OF EMPLOYES. (a) Except as provided in par.
5 (d), requirements used by ~~a small employer~~ an insurer in determining whether to
6 provide coverage to ~~a small~~ an employer, including requirements for minimum
7 participation of eligible employees and minimum employer contributions, shall be
8 applied uniformly among all ~~small~~ employers that apply for or receive coverage from
9 the ~~small employer~~ insurer and that have the same number of eligible employees.

10 (b) ~~A small employer~~ An insurer may vary its minimum participation
11 requirements and minimum employer contribution requirements only by the size of
12 the ~~small~~ employer group.

13 (c) 1. Except as provided in subd. 2., in applying minimum participation
14 requirements with respect to ~~a small~~ an employer, ~~a small employer~~ an insurer may
15 not count eligible employees or their dependents who have other coverage that is
16 qualifying coverage in determining whether the applicable percentage of
17 participation is met.

18 2. If ~~a small~~ an employer has 10 or fewer eligible employees, ~~a small employer~~
19 an insurer may count eligible employees or their dependents who have coverage under
20 another health benefit plan sponsored by that ~~small~~ employer in applying minimum
21 participation requirements to determine whether the applicable percentage of
22 participation is met.

23 (d) ~~A small employer~~ An insurer may not increase a requirement for minimum
24 employe participation or a requirement for minimum employer contribution that

1 applies to a ~~small~~ an employer after the ~~small~~ employer has been accepted for
2 coverage.

3 **SECTION 68.** 635.17 (3) of the statutes is amended to read:

4 635.17 (3) PROHIBITED COVERAGE PRACTICES. (a) If a ~~small employer~~ an insurer
5 offers coverage to a ~~small~~ an employer, the ~~small employer~~ insurer shall offer
6 coverage to all of the eligible employes of the ~~small~~ employer and their dependents.
7 ~~A small employer~~ An insurer may not offer coverage to only certain individuals in a
8 ~~small~~ an employer group or to only part of the group, except for an eligible employe
9 who has not yet satisfied an applicable waiting period, if any.

10 (b) ~~A small employer~~ An insurer may not modify a health benefit plan subject
11 to this subchapter with respect to a ~~small~~ an employer or an eligible employe or
12 dependent, through riders, endorsements or otherwise, to restrict or exclude
13 coverage for certain diseases or medical conditions otherwise covered by the health
14 benefit plan.

15 **SECTION 69.** 635.18 (1) of the statutes is renumbered 635.18 (1) (intro.) and
16 amended to read:

17 635.18 (1) (intro.) Every ~~small employer~~ insurer that provides coverage under
18 a health benefit plan subject to this subchapter shall actively market such health
19 benefit plan coverage, ~~including basic health benefit plans, to small employers in the~~
20 ~~state. If a small employer insurer denies coverage to a small employer under a health~~
21 ~~benefit plan that is not a basic health benefit plan on the basis of the health status~~
22 ~~or claims experience of the small employer or its eligible employes or their~~
23 ~~dependents, the small employer insurer shall offer the small employer the~~
24 opportunity to purchase a basic health benefit plan. In addition to other marketing

1 limitations that the commissioner may authorize by rule, an insurer may limit its
2 marketing under this subsection to any of the following:

3 **SECTION 70.** 635.18 (1) (a) to (c) of the statutes are created to read:

4 635.18 (1) (a) Health benefit plans for small employer groups of all sizes.

5 (b) Health benefit plans for employer groups of all sizes that are not small
6 employer groups.

7 (c) Health benefit plans for individuals.

8 **SECTION 71.** 635.18 (2) of the statutes is amended to read:

9 635.18 (2) (a) Except as provided in par. (b), a ~~small employer~~ an insurer or an
10 intermediary may not, directly or indirectly, do any of the following:

11 1. Discourage a ~~small~~ an employer or an individual from applying, or direct a
12 ~~small~~ an employer or an individual not to apply, for coverage with the ~~small employer~~
13 insurer because of the health status condition, claims experience, industry,
14 occupation or geographic ~~location~~ area of the ~~small employer~~ or individual.

15 2. Encourage or direct a ~~small~~ an employer or an individual to seek coverage
16 from another insurer because of the health status condition, claims experience,
17 industry, occupation or geographic ~~location~~ area of the ~~small employer~~ or individual.

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

22 **SECTION 72.** 635.18 (3) of the statutes is amended to read:

23 635.18 (3) (a) Except as provided in par. (b), a ~~small employer~~ an insurer may
24 not, directly or indirectly, enter into any contract, agreement or arrangement with
25 an intermediary that provides for or results in compensation to ~~an~~ the intermediary

1 for the sale of a health benefit plan subject to this subchapter that varies according
2 to the health status condition, claims experience, industry, occupation or geographic
3 ~~location~~ area of the ~~small employer or~~ eligible employes, insured individual or
4 dependents.

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

9 (c) ~~A small employer~~ An insurer shall provide reasonable compensation to an
10 intermediary, if any, for the sale of a basic health benefit plan.

11 **SECTION 73.** 635.18 (4) of the statutes is amended to read:

12 635.18 (4) ~~A small employer~~ An insurer may not terminate, fail to renew or
13 limit its contract or agreement of representation with an intermediary for any reason
14 related to the health status condition, claims experience, occupation or geographic
15 ~~location~~ area of the ~~small employers or~~ eligible employes, insured individuals or
16 ~~their~~ dependents placed by the intermediary with the ~~small employer~~ insurer.

17 **SECTION 74.** 635.18 (5) of the statutes is amended to read:

18 635.18 (5) ~~A small employer~~ An insurer or an intermediary may not induce or
19 otherwise encourage a ~~small~~ an employer to separate or otherwise exclude an
20 employe from health coverage or benefits provided in connection with the employe's
21 employment.

22 **SECTION 75.** 635.18 (6) of the statutes is amended to read:

23 635.18 (6) Denial by a ~~small employer~~ an insurer of an application for coverage
24 ~~from a small employer~~ under a health benefit plan subject to this subchapter shall
25 be in writing and shall state the reason or reasons for the denial.

1 **SECTION 76.** 635.18 (7) of the statutes is amended to read:

2 635.18 (7) A 3rd-party administrator that enters into a contract, agreement
3 or other arrangement with a ~~small employer~~ an insurer to provide administrative,
4 marketing or other services related to the offering of health benefit plans subject to
5 this subchapter to ~~small employers~~ or individuals in this state is subject to this
6 subchapter as if it were a ~~small employer~~ an insurer.

7 **SECTION 77.** 635.18 (8) of the statutes is amended to read:

8 635.18 (8) The commissioner may by rule establish additional standards to
9 provide for the fair marketing and broad availability of health benefit plans subject
10 to this subchapter to ~~small employers~~ and individuals in this state, including
11 requirements designed to prevent evasion of the purposes of this chapter.

12 **SECTION 78.** 635.18 (9), (9m) and (10) of the statutes are created to read:

13 635.18 (9) An insurer that has in force one or more health benefit plans that
14 are included in a category under sub. (1) (a) to (c) and that are subject to this
15 subchapter shall actively market and issue health benefit plans in that category, as
16 provided in s. 635.15, unless the insurer complies with all of the following:

17 (a) Files notice with the commissioner that the insurer is ceasing to issue health
18 benefit plans in that category.

19 (b) Except as provided in sub. (9m), ceases to issue health benefit plans in that
20 category for not less than 5 years.

21 (c) Except as provided in sub. (9m), does not commence marketing or issuing
22 health benefit plans in that category until the insurer files notice with the
23 commissioner that the insurer intends to market and issue such health benefit plans.

24 **(9m)** If an insurer ceases to issue health benefit plans in the category under
25 sub. (1) (c) but continues to issue health benefit plans in a category under sub. (1) (a)

1 or (b), the insurer shall continue to issue individual conversion policies, as provided
2 in s. 635.15, and sub. (9) (b) and (c) does not apply to those policies.

3 **(10)** An insurer may not cease to actively market or issue health benefit plans
4 in all categories under sub. (1) (a) to (c) unless the insurer complies with s. 635.07
5 (2).

6 **SECTION 79.** 635.20 (1) of the statutes is amended to read:

7 635.20 (1) "Basic benefits" means the minimum benefits established by the
8 plan board under s. 635.21, 1993 stats., and s. 635.23 (1) (a), 1993 stats., or the board
9 under ss. 635.21 and 635.23 (1) (a), and includes all health insurance mandates to
10 the extent determined by the plan board under s. 635.23 (1) (b), 1993 stats., or the
11 board under s. 635.23 (1) (b).

12 **SECTION 80.** 635.20 (1b) of the statutes is created to read:

13 635.20 (1b) "Board" means the comprehensive health care board.

14 **SECTION 81.** 635.20 (2) of the statutes is amended to read:

15 635.20 (2) "Eligible small employer" means an employer that satisfies the
16 requirements of s. 635.25 (1).

17 **SECTION 82.** 635.20 (11) of the statutes is amended to read:

18 635.20 (11) "Plan board" means the small employer insurance board created
19 under s. 15.735 (1), 1993 stats.

20 **SECTION 83.** 635.20 (13) of the statutes is repealed and recreated to read:

21 635.20 (13) "Small employer insurer" means an insurer that is authorized to
22 do business in this state, in one or more lines of insurance that includes health
23 insurance, and that offers group health benefit plans covering eligible employees of
24 one or more small employers in this state, or that sells 3 or more individual health
25 benefit plans to a small employer, covering eligible employees of the small employer.

1 The term includes a health maintenance organization, as defined in s. 609.01 (2), a
2 preferred provider plan, as defined in s. 609.01 (4), and an insurer operating as a
3 cooperative association organized under ss. 185.981 to 185.985, but does not include
4 a limited service health organization, as defined in s. 609.01 (3).

5 **SECTION 84.** 635.21 of the statutes is amended to read:

6 **635.21 Establishment of plan.** There is established a plan of health
7 insurance coverage for individuals employed by small employers. The ~~plan~~ board
8 shall formulate, supervise and modify the plan as needed, and shall promulgate
9 rules regarding the establishment and administration of the plan.

10 **SECTION 85.** 635.23 (title) and (1) (intro.) of the statutes are amended to read:

11 **635.23 (title) Duties of ~~plan~~ board.** (1) (intro.) The ~~plan~~ board shall:

12 **SECTION 86.** 635.23 (1) (a), (d), (dp), (dr) and (e) (intro.), 1., 2. and 3. of the
13 statutes are amended to read:

14 635.23 (1) (a) By rule determine the basic benefits that small employer insurers
15 may offer to eligible small employers for providing coverage to eligible employes and
16 their dependents.

17 (d) By rule establish small employer eligibility requirements for ~~participation~~
18 in the plan the purchase of a policy providing the basic benefits.

19 (dp) By rule determine whether small employers ~~participating in the plan that~~
20 purchase a policy providing the basic benefits may impose a probationary or waiting
21 period on employes who become eligible for coverage after the commencement of the
22 small employer's coverage. The ~~plan~~ board may not allow for a probationary or
23 waiting period that exceeds 90 days.

24 (dr) By rule determine enrollment periods, if any, for small employer or
25 employe coverage under the plan.

1 (e) (intro.) Annually submit a report to the chief clerk of each house of the
2 legislature, for distribution under s. 13.172 (3) to the appropriate standing
3 committees, under s. 13.172 (3) summarizing the activities of the plan board and the
4 operation of the plan in the preceding year, and including but not limited to all of the
5 following:

6 1. The number of small employers ~~participating in the plan~~ purchasing a policy
7 providing the basic benefits.

8 2. The number of employes and dependents ~~participating in the plan~~ covered
9 under a policy providing the basic benefits.

10 3. An evaluation of the plan's operation and, effectiveness and availability.

11 **SECTION 87.** 635.23 (1m) of the statutes is amended to read:

12 635.23 (1m) The plan board may by rule establish plan features in addition to
13 those specified in sub. (1).

14 **SECTION 88.** 635.23 (1r) of the statutes is amended to read:

15 635.23 (1r) All aspects of the composition and operation of the plan that are
16 established by the plan board shall be established by rule.

17 **SECTION 89.** 635.23 (2) of the statutes is amended to read:

18 635.23 (2) All rules promulgated by the plan board are subject to approval by
19 the commissioner.

20 **SECTION 90.** 635.23 (3) of the statutes is repealed.

21 **SECTION 91.** 635.23 (4) and (5) of the statutes are amended to read:

22 635.23 (4) In the formulation of the plan, for the purpose of cost containment
23 the plan board shall encourage the use, to the extent possible, of the services of health
24 care providers other than physicians. The plan board shall report any
25 recommendations on ways to encourage the use of the services of health care

1 providers other than physicians to the chief clerk of each house of the legislature for
2 distribution under s. 13.172 (3) to the standing committees with jurisdiction over
3 health insurance under s. 13.172 (3).

4 (5) The plan board may submit any recommendations for legislation to improve
5 the plan to the chief clerk of each house of the legislature for distribution under s.
6 13.172 (3) to the standing committees with jurisdiction over health insurance under
7 s. 13.172 (3).

8 **SECTION 92.** 635.25 (title) of the statutes is amended to read:

9 **635.25** (title) **Eligibility for participation in plan.**

10 **SECTION 93.** 635.25 (1) (a) (intro.) of the statutes is amended to read:

11 635.25 (1) (a) (intro.) To be eligible to participate in the plan by purchasing
12 purchase a policy under this subchapter containing the basic benefits, an employer:

13 **SECTION 94.** 635.25 (1) (a) 2. of the statutes is amended to read:

14 635.25 (1) (a) 2. Must comply with any other eligibility requirements specified
15 by the plan board under s. 635.25 (1) (a) 2., 1993 stats., or by the board.

16 **SECTION 95.** 635.25 (1) (b) of the statutes is amended to read:

17 635.25 (1) (b) Except as provided in ss. 645.43 and 646.35, an a small employer
18 that purchases a policy under this subchapter containing the basic benefits and that
19 ceases to be eligible to ~~participate in the plan~~ during a policy period shall retain
20 coverage under the plan policy to the end of the policy period.

21 **SECTION 96.** 635.25 (1m) of the statutes is amended to read:

22 635.25 (1m) Notwithstanding sub. (1), an a small employer is not eligible to
23 ~~participate in the plan~~ purchase a policy under this subchapter containing the basic
24 benefits if all of the individuals to be covered under the plan policy may be covered
25 ~~by a single~~ under an individual policy providing individual single or family coverage.

1 **SECTION 97.** 635.25 (2) of the statutes is amended to read:

2 635.25 (2) EMPLOYES AND DEPENDENTS. (a) All eligible employes of an eligible
3 small employer that ~~partieipates in the plan~~ purchases a policy under this
4 subchapter are eligible for coverage under the ~~plan~~ policy, subject to the policy terms.

5 (b) Any dependent of an eligible employe who is covered under the ~~plan~~ policy
6 is also eligible for coverage under the ~~plan~~ policy, subject to the policy terms.

7 **SECTION 98.** 635.254 of the statutes is amended to read:

8 **635.254 Employer premium contribution. (1)** ~~An~~ A small employer that
9 ~~partieipates in the plan~~ purchases a policy under this subchapter shall pay a
10 premium contribution of not less than 50% of the premium rate on behalf of an
11 eligible employe with ~~individual~~ single coverage and not less than 40% of the
12 premium rate on behalf of an eligible employe with family coverage.

13 **(2)** ~~An~~ A small employer under sub. (1) shall withhold from the earnings of an
14 employe with coverage under the ~~plan~~ policy under this subchapter the amount of
15 premium not contributed by the small employer under sub. (1).

16 **(3)** For an eligible employe who obtains coverage under the health insurance
17 risk-sharing plan under s. 619.12 (2) (e) 2., ~~an~~ a small employer under sub. (1) shall
18 pay a premium contribution to the health insurance risk-sharing plan that is equal
19 to the amount that the small employer would pay on behalf of the employe for
20 coverage under the ~~plan~~ policy under this subchapter.

21 **SECTION 99.** 635.26 (1) of the statutes is amended to read:

22 635.26 (1) (a) Except as provided in subs. (2m) to (4) ~~(5)~~, a small employer
23 insurer shall provide coverage under ~~the plan~~ a policy under this subchapter,
24 regardless of health ~~status~~ condition or claims experience, to an eligible small

1 employer and to all of its eligible employees and their dependents if all of the following
2 apply:

3 1. The small employer agrees to pay the premium required for coverage under
4 the plan policy.

5 2. The small employer agrees to comply with all other plan policy provisions
6 that apply generally to a policyholder or an insured without regard to health status
7 condition or claims experience.

8 (b) Except as provided in subs. (2m) to (4) (5), a small employer insurer shall
9 provide coverage under ~~the plan~~ a policy under this subchapter, regardless of health
10 ~~status~~ condition or claims experience, to an eligible employee who becomes eligible for
11 coverage after the commencement of the small employer's coverage, and to the
12 eligible employee's dependents, if all of the following apply:

13 1. The employee applies for coverage under the plan policy before the expiration
14 of any applicable enrollment period, if any, required under the plan policy.

15 2. The small employer agrees to pay the premium required for coverage of the
16 employee under the plan policy.

17 **SECTION 100.** 635.26 (1m) of the statutes is amended to read:

18 635.26 (1m) A small employer insurer shall be in compliance with sub. (1) if
19 it issues a policy that complies with the plan and the minimum benefit standards
20 determined by the plan board under s. 635.23 (1) (c), 1993 stats., or the board under
21 s. 635.23 (1) (c) but that includes only the basic benefits.

22 **SECTION 101.** 635.26 (1s) of the statutes is amended to read:

23 635.26 (1s) Nothing in sub. (1) prohibits a small employer insurer that provides
24 coverage under sub. (1) from imposing preexisting condition provisions, waiting

1 period requirements, or other provisions or requirements related to health status
2 condition or claims experience, that are permitted or required under the plan policy.

3 **SECTION 102.** 635.26 (4) of the statutes is amended to read:

4 635.26 (4) A small employer insurer that offers health insurance coverage
5 exclusively to a single category or limited categories of eligible small employers is
6 required to comply may, with the prior approval of the commissioner, limit its
7 compliance with sub. (1) only as to that single category or those limited categories
8 of eligible small employers.

9 **SECTION 103.** 635.26 (5) of the statutes is created to read:

10 635.26 (5) (a) In this subsection, “municipal” means county, city, village, town
11 or school district.

12 (b) Subsection (1) does not require a small employer insurer to issue coverage
13 that the small employer insurer is not authorized to issue under its bylaws, charter
14 or certificate of incorporation or authority if the small employer insurer is authorized
15 under its bylaws, charter or certificate of incorporation or authority to issue coverage
16 only to state or municipal employees and former employees and their dependents.

17 **SECTION 104.** 635.272 (1) of the statutes is amended to read:

18 635.272 (1) CONTRACTING HEALTH CARE PROVIDERS. A health care provider that
19 contracts with a small employer insurer to provide services to individuals with
20 coverage under the plan a policy under this subchapter shall accept amounts payable
21 under the contract for the basic benefits under the policy as payment in full for those
22 services. This subsection does not affect liability for deductibles or copayments.

23 **SECTION 105.** 635.28 of the statutes is amended to read:

24 **635.28 (title) Liability of state and plan board.** Neither the state nor the
25 plan board is liable for any obligation arising under the plan. Plan board Board

1 members are immune from civil liability for acts or omissions ~~while performing in~~
2 the performance of their duties under this subchapter.

3 **SECTION 106.** 635.29 of the statutes is amended to read:

4 **635.29** (title) ~~Exemption from required coverage~~ **Applicability of health**
5 **insurance mandates.** The health insurance mandates apply to the plan under this
6 subchapter only to the extent determined by the plan board under s. 635.23 (1) (b),
7 1993 stats., or the board under s. 635.23 (1) (b).

8 **SECTION 107. Nonstatutory provisions; insurance.**

9 (1) COMPREHENSIVE HEALTH CARE BOARD; INITIAL MEMBERSHIP. Notwithstanding
10 the length of terms specified for the members of the comprehensive health care board
11 under section 15.735 (3) (b) of the statutes, as created by this act, and the manner
12 of appointment specified for the members of the board under section 15.07 (1) (b) of
13 the statutes, the following initial members of the board shall be appointed by the
14 governor by the first day of the 4th month beginning after the effective date of this
15 subsection for the following terms:

16 (a) Four members, 2 of whom represent employers, one of whom represents
17 eligible employees and one of whom represents a purchasing coalition, for terms
18 expiring on May 1, 1996.

19 (b) Four members, one of whom represents employers, one of whom represents
20 eligible employees, one of whom represents a labor organization and one of whom
21 represents a purchasing coalition, for terms expiring on May 1, 1997.

22 (c) Four members, 2 of whom represent employers, one of whom represents
23 eligible employees and one of whom represents a purchasing coalition, for terms
24 expiring on May 1, 1998.

25 (2) STUDIES.

1 (a) The comprehensive health care board shall study all of the following:

2 1. The feasibility of an electronic central claim and data clearinghouse to
3 which insurers and health care providers would have access. The comprehensive
4 health care board shall also study the feasibility of using such a clearinghouse to
5 collect data on patient outcomes and health care delivery costs and for research. In
6 conjunction with these issues, the comprehensive health care board shall study
7 appropriate measures for ensuring confidentiality of patient information under the
8 clearinghouse method of data collection and transmission. The comprehensive
9 health care board shall submit the results of and recommendations from this study
10 as provided under paragraph (c) no later than January 1, 1997.

11 2. Alternative approaches to address individual responsibility, including a
12 requirement that all residents of the state obtain health insurance coverage. As part
13 of the study, the comprehensive health care board shall examine the likelihood that
14 a federal waiver would be granted, or that federal legislation would be enacted, that
15 would allow for coverage of medical assistance recipients under individual health
16 insurance policies and that would allow for use of federal financial participation
17 under the medical assistance program to help subsidize the cost of health insurance
18 premiums for low-income individuals. The comprehensive health care board shall
19 submit recommendations as provided under paragraph (c) no later than 15 months
20 after the effective date of this subdivision. The legislature shall seek to implement
21 the board's recommendations by January 1, 1999.

22 (b) The commissioner of insurance shall study the feasibility of modifying
23 community rates by taking into account an insured's successful use of preventive
24 health care, efficient and effective health care consumption and healthy lifestyle
25 choices in reducing the insured's health care costs. The commissioner shall submit

1 the results of and recommendations from this study as provided under paragraph (c)
2 no later than January 1, 1997.

3 (c) The comprehensive health care board and the commissioner shall submit
4 the results of the studies and any recommendations to the legislature in the manner
5 provided under section 13.172 (2) of the statutes and to the governor.

6 (3) REINSURANCE PROGRAM. No later than 6 months after the effective date of this
7 subsection, the comprehensive health care board shall submit proposed legislation
8 to the appropriate standing committees of the legislature, as designated by the
9 presiding officer of each house, that provides for a reinsurance program for insurers
10 that are subject to the market reform requirements under chapter 635 of the
11 statutes, as affected by this act. The reinsurance program shall contain at least all
12 of the following features:

13 (a) The reinsurance program shall be optional, but an insurer that
14 participates shall participate for a minimum of 2 years.

15 (b) An insurer that participates shall provide coverage under the reinsurance
16 program for all health benefit plans that the insurer issues or renews and that are
17 subject to subchapter I of chapter 635 of the statutes, as affected by this act.

18 (c) The commissioner of insurance shall administer the reinsurance program
19 and shall provide for an open enrollment period from January 1 to February 1 every
20 2 years.

21 (d) A participating insurer shall be required to select one of the following as
22 the insurer's threshold amount for a 2-year period:

- 23 1. Per individual per year, \$50,000.
- 24 2. Per individual per year, \$150,000.
- 25 3. Per individual per year, \$250,000.

1 (e) The commissioner of insurance shall be required to reimburse a
2 participating insurer for 80% of the amount of claims for covered expenses that
3 exceeds the insurer's threshold amount.

4 (f) The commissioner of insurance shall be required to appoint a reinsurance
5 technical committee, consisting of at least 3 qualified and disinterested persons, to
6 determine annually on an actuarial basis the premium that each insurer
7 participating in the reinsurance program shall pay for coverage under the
8 reinsurance program. In determining the premium, the committee shall take into
9 consideration the insurer's threshold amount. Each participating insurer shall pay
10 the premium to the commissioner of insurance for deposit in a health reinsurance
11 fund.

12 (g) The commissioner of insurance shall be authorized to impose an
13 assessment against each insurer participating in the reinsurance program if the
14 commissioner determines that moneys in the health reinsurance fund will be
15 insufficient to reimburse insurers.

16 **SECTION 108. Initial applicability; insurance.**

17 (1) MARKET REFORM. The treatment of sections 111.70 (1) (a) and (4) (m), 625.12
18 (2), 628.34 (3), 632.897 (2) (d) and (9) (c), 635.01, 635.02 (1), (2), (3), (3f), (3h), (3j),
19 (3m), (4g), (4m), (5), (5m) (d), (6), (6m), (7) (intro.), (a) and (b) and (8), 635.05, 635.06,
20 635.07 (1) (intro.), (b), (d), (e) and (f), (2) and (3), 635.09, 635.11 (ar) (intro.), (1) and
21 (4), 635.13 (2), 635.15 (1), (2) and (3), 635.17 (title), (1) (a) (intro.) and 3., (ac), (am),
22 (ar), (b) 1., 2. and 3. and (c), (2) and (3) and 635.18 (2), (3), (4), (5), (6), (7), (8), (9), (9m)
23 and (10) and chapter 635 (title) of the statutes, the renumbering and amendment of
24 sections 635.17 (1) (a) 1. and 2. and 635.18 (1) of the statutes, the repeal and
25 recreation of section 635.13 (1) of the statutes and the creation of sections 635.17 (1)

1 (a) 1. b. and 2. b. and 635.18 (1) (a) to (c) of the statutes first apply to all of the
2 following:

3 (a) Group health benefit plans providing coverage for eligible employees, as
4 defined in section 635.02 (3f) of the statutes, as affected by this act, of an employer,
5 as defined in section 635.02 (3h) of the statutes, as created by this act, issued or
6 renewed on the effective date of this paragraph.

7 (b) Individual health benefit plans issued on the effective date of this
8 paragraph to a policyholder who is a resident of this state, or renewed on the effective
9 date of this paragraph to a policyholder who is a resident of this state and who was
10 a resident of this state when the policy was first issued.

11 **SECTION 109. Effective dates; insurance.** This act takes effect on the day
12 after publication, except as follows:

13 (1) MARKET REFORM. The treatment of sections 111.70 (1) (a) and (4) (m),
14 601.424, 625.12 (2), 628.34 (3), 632.897 (2) (d) and (9) (c), 635.01, 635.02 (1), (2), (3),
15 (3f), (3h), (3j), (3m), (4g), (4m), (5), (5m) (d), (6), (6m), (7) (intro.), (a) and (b) and (8),
16 635.05, 635.06, 635.07 (1) (intro.), (b), (d), (e) and (f), (2) and (3), 635.09, 635.11
17 (intro.), (1) and (4), 635.13 (2), 635.15, 635.17 (title), (1) (a) (intro.) and 3., (ac), (am),
18 (ar), (b) 1., 2. and 3. and (c), (2) and (3) and 635.18 (2), (3), (4), (5), (6), (7), (8), (9), (9m)
19 and (10) and chapter 635 (title) of the statutes, the renumbering and amendment of
20 sections 635.17 (1) (a) 1. and 2. and 635.18 (1) of the statutes, the repeal and
21 recreation of section 635.13 (1) of the statutes, the creation of sections 635.17 (1) (a)
22 1. b. and 2. b. and 635.18 (1) (a) to (c) of the statutes and SECTIONS 107 and 108 (1) of
23 this act take effect on the first day of the 12th month beginning after publication.

24 (2) SMALL EMPLOYER HEALTH INSURANCE PLAN. The treatment of sections 15.735
25 (1), 185.983 (1g), 628.36 (2) (b) 5., 632.70, 635.03, 635.20 (1), (1b), (2), (11) and (13),

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1 635.21, 635.23 (title), (1) (intro.), (a), (d), (dp), (dr) and (e) (intro.), 1., 2. and 3., (1m),
2 (1r), (2), (3), (4) and (5), 635.25 (title), (1) (a) (intro.) and 2. and (b), (1m) and (2),
3 635.254, 635.26 (1), (1m), (1s), (4) and (5), 635.272 (1), 635.28 and 635.29 of the
4 statutes and the amendment of section 635.13 (1) of the statutes take effect on the
5 first day of the 4th month beginning after publication.

6

(END)