CHAPTER 635

SMALL EMPLOYER HEALTH INSURANCE

Cross−references: See definitions in ss. 600.03 and 628.02.

SUBCHAPTER I

GENERAL PROVISIONS

635.01 Scope. This subchapter applies to all group health insurance plans, policies or certificates, written on risks or operations in this state, providing coverage for employes of a small employer, or employes of a small employer and the employer, and to individual health insurance policies, written on risks or operations in this state, providing coverage for employes of a small employer, or employes of a small employer and the employer when 3 or more are sold to a small employer.

History: 1991 a. 39.

635.02 Definitions. In this subchapter:

(1) "Base premium rate" means the lowest premium rate chargeable under a rating system to small employers with similar case characteristics and the same or similar benefit design characteristics in the same class of business.

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

(1m) "Benefit design characteristics" means covered services, cost sharing, utilization management, managed care networks and other features that differentiate plan or coverage designs.

(2) "Case characteristics" means the demographic, actuarially based characteristics of the employes of a small employer, and the employer, if covered, such as age, sex, geographic location and occupation, used by a small employer insurer to determine premium rates for a small employer. "Case characteristics" does not include loss or claim history, health status, duration of coverage or other factors related to claim experience.

(3) "Class of business" means all or a distinct grouping of small employers determined in accordance with rules promulgated by the commissioner under s. 635.05 (4).

(3c) "Dependent" means a spouse, an unmarried child under the age of 19 years, an unmarried child who is a full−time student under the age of 21 years and who is financially dependent upon the parent, or an unmarried child of any age who is medically certified as disabled and who is dependent upon the parent.

(3f) "Eligible employe" means an employe who works on a full−time basis and has a normal work week of 30 or more hours. The term includes a sole proprietor, a business owner, including the owner of a farm business, a partner of a partnership, a member of a limited liability company and an independent contractor if the sole proprietor, business owner, partner, member or independent contractor is included as an employe under a health benefit plan of a small employer, but the term does not include an employe who works on a part−time, temporary or substitute basis.

(3j) "Established geographic service area" means a geographic area within which a small employer insurer provides coverage and that has been approved by the commissioner.

(3m) "Health benefit plan" means any hospital or medical policy or certificate. "Health benefit plan" does not include accident−only, credit, dental, vision, medicare supplement, long−term care, or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or other insurance exempted by rule of the commissioner.

(4m) "Midpoint rate" means the arithmetic average of the base premium rate and the corresponding highest premium rate.

(5) "New business premium rate" means the premium rate charged or offered to small employers with similar case characteristics in the same class of business for newly issued health insurance with the same or similar benefit design characteristics.

(5m) (a) "Qualifying coverage" means benefits or coverage provided under any of the following:

1. Medicare or medicaid.

2. An employer−based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under a basic health benefit plan.

3. An individual health insurance policy that provides benefits similar to or exceeding benefits provided under a basic health benefit plan, if the policy has been in effect for at least one year.

(b) Notwithstanding par. (a) 2. and 3., "qualifying coverage" does not include a high cost−share health plan, as defined in s. 632.898 (1) (c), that is linked to a medical savings account, as described in s. 632.898, if any of the following applies:

1. The health benefit plan that is the individual's new coverage and the health benefit plan that is the individual's previous coverage are provided by the same small employer.

2. The health benefit plan that is the individual's new coverage is provided by a small employer that is not the same employer that provided the health benefit plan that was the individual's previous coverage, the small employer that provides the individual's new coverage offers its eligible employes a choice of health benefit plan options that includes a high cost−share health plan, as defined in s. 632.898 (1) (c), and the individual's new coverage is not a high cost−share health plan.

NOTE: Sub. (5m) is repealed eff. 5−1−97 by 1995 Wis. Act 289.

(6) "Rating period" means the period, determined by a small employer insurer, during which a premium rate established by the small employer insurer remains in effect.

(6m) "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 small employer insurer to provide health care services or articles to covered individuals.

(7) "Small employer" means any of the following:

(a) An individual, firm, corporation, partnership, limited liability company or association that is actively engaged in a business enterprise in this state, including a farm business, and that employs in this state not fewer than 2 nor more than 25 eligible employes. In determining the number of eligible employes, employers that are affiliated, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

(b) A village or town that provides or that is eligible under s. 635.25 (1) to provide coverage to its eligible employes under a basic health benefit plan.

(8) "Small employer insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers group health benefit plans covering eligible employes of one or more small employers in this state, or that sells 3 or more individual health benefit plans to a small employer, covering eligible employes of the small employer. The term includes a health maintenance organization, as defined in s. 609.01 (2), a preferred provider plan, as defined in s. 609.01 (4), and an insurer operating as a cooperative association organized under ss. 185.981 to 185.985, but does not include a limited service health organization, as defined in s. 609.01 (3).

History: 1991 a. 39, 250; 1993 a. 112; 1995 a. 289, 453.

635.05 Rate regulation. Notwithstanding ch. 625, the commissioner shall promulgate rules:

(1) Establishing restrictions on premium rates that a small employer insurer may charge a small employer such that the premium rates charged to small employers with similar case characteristics for the same or similar benefit design characteristics do not vary from the midpoint rate for those small employers by more than 35% of that midpoint rate.

(2) Establishing restrictions on increases in premium rates that a small employer insurer may charge a small employer such that:

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

1. 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, or the percentage change in the base premium rate in the case of a class of business for which the small employer insurer is not issuing new policies.

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

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

(b) The percentage increase in the premium rate for a new rating period for a policy issued before August 15, 1991, does not exceed the sum of par. (a) 1. and 3., unless premium rates are in compliance with the rules promulgated under sub. (1).

(3) Requiring the premium rate of a policy issued before August 15, 1991, to comply with the rules promulgated under sub. (1) no later than 3 years after August 15, 1991.

(4) Defining the terms necessary for compliance with this section.

(5) Ensuring that small employers are classified using objective criteria.

(6) Ensuring that rating factors are applied objectively and consistently within a class of business.

History: 1991 a. 39, 250.

635.07 Contract termination and renewability. (1) Notwithstanding s. 631.36 (2) to (4m), a plan or policy subject to this subchapter may not be canceled by an insurer before the expiration of the agreed term, and shall be renewable to the employer and all employes and dependents eligible under the terms of the plan or policy at the expiration of the agreed term at the option of the small employer, except for any of the following reasons:

(a) Failure to pay a premium when due.

(b) Fraud or misrepresentation by the small employer, or, with respect to coverage for an insured individual, fraud or misrepresentation by the insured individual.

(c) Substantial breaches of contractual duties, conditions or warranties.

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

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

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

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

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

(c) The small employer insurer does not establish a new class of business earlier than 5 years after the nonrenewal of the plans or policies.

(d) The small employer insurer does not transfer or otherwise provide coverage to a small employer from the nonrenewed class of business unless the small employer insurer offers to transfer or provide coverage to all affected small employers from the nonrenewed class of business without regard to case characteristics, claim experience, health status or duration of coverage.

(3) This section does not apply to a plan or policy subject to this subchapter if the small employer insurer that issued the policy is in liquidation.

NOTE: This section is repealed eff. 5−1−97 by 1995 Wis. Act 289.

History: 1991 a. 39, 250; 1995 a. 289.

635.09 Prohibited denial of coverage. No small employer insurer may refuse to provide coverage for employes of a small employer solely on the basis of the occupation of the employes or the type of business in which the small employer is engaged.

History: 1991 a. 39, 250.

635.11 Disclosure of rating factors and renewability provisions. Before the sale of a plan or policy subject to this subchapter, a small employer insurer shall disclose to a small employer all of the following:

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

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

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

(4) The small employer's renewability rights.

History: 1991 a. 39, 250, 315.

635.13 Annual certification of compliance. (1) RECORDS. A small employer insurer shall maintain at its principal place of business complete and detailed records relating to its rating methods and practices and its renewal underwriting methods and practices, and shall make the records available to the

commissioner and the small employer insurance board upon request.

(2) CERTIFICATION. A small employer insurer 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:

(a) That the small employer insurer is in compliance with the rate provisions of s. 635.05.

(b) That the small employer 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 small employer insurer's records and a review of the small employer insurer's actuarial assumptions and statistical methods used in setting rates and procedures used in implementing rating plans.

History: 1991 a. 39, 250.

635.15 Temporary suspension of rate regulation. The commissioner may suspend the operation of all or any part of s. 635.05 with respect to one or more small employers for one or more rating periods upon the written request of a small employer insurer and a finding by the commissioner that the suspension is necessary in light of the financial condition of the small employer insurer or that the suspension would enhance the efficiency and fairness of the small employer health insurance market.

History: 1991 a. 39, 250.

635.17 Coverage requirements for small employer plans. (1) UNDERWRITING, PORTABILITY AND PREEXISTING CONDITIONS. (a) A health benefit plan subject to this subchapter may not deny, exclude or limit benefits for a covered individual for losses incurred more than 12 months after the effective date of the individual's coverage due to a preexisting condition. Such a 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 6 months immediately preceding the effective date of coverage.

2. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the effective date of coverage.

3. A pregnancy existing on the effective date of coverage.

(b) 1. A health benefit plan subject to this subchapter shall waive any period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period that an individual was previously covered by qualifying coverage that provided benefits with respect to such services, if the qualifying coverage was continuous to a date not more than 30 days before the effective date of the new coverage.

2. Subdivision 1. does not prohibit the application of a waiting period to all new enrollees under the health benefit plan; however, a waiting period may not be counted when determining whether the qualifying coverage was continuous to a date not more than 30 days before the effective date of the new coverage. For the purpose of subd. 1., the new coverage shall be considered effective as of the date that it would be effective but for the waiting period.

3. Until June 1, 1993, subd. 1. does not apply to a health benefit plan that is not a basic health benefit plan if the previous qualifying coverage was a basic health benefit plan.

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

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

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

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

(d) A small employer insurer may not increase a requirement for minimum employe participation or a requirement for minimum employer contribution that applies to a small employer after the small employer has been accepted for coverage.

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

(b) A small employer insurer may not modify a health benefit plan with respect to a small employer or an eligible employe or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

NOTE: This section is repealed eff. 5−1−97 by 1995 Wis. Act 289.

History: 1991 a. 250; 1995 a. 289, 412.

635.18 Fair marketing standards. (1) Every small employer insurer shall actively market health benefit plan coverage, including basic health benefit plans, to small employers in the state. If a small employer insurer denies coverage to a small employer under a health benefit plan that is not a basic health benefit plan on the basis of the health status or claims experience of the small employer or its eligible employes or their dependents, the small employer insurer shall offer the small employer the opportunity to purchase a basic health benefit plan.

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

1. Discourage a small employer from applying, or direct a small employer not to apply, for coverage with the small employer insurer because of the health status, claims experience, industry, occupation or geographic location of the small employer.

2. Encourage or direct a small employer to seek coverage from another insurer because of the health status, claims experience, industry, occupation or geographic location of the small employer.

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

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

or geographic area of the small employer or eligible employes or dependents.

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

(4) A small employer 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 status, claims experience, occupation or geographic location of the small employers or eligible employes or their dependents placed by the intermediary with the small employer insurer.

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

(6) Denial by a small employer insurer of an application for coverage from a small employer 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 a small employer insurer to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state is subject to this subchapter as if it were a small employer insurer.

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

History: 1991 a. 250, 315.

SUBCHAPTER II

SMALL EMPLOYER HEALTH INSURANCE PLAN

635.20 Definitions. In this subchapter:

(1) "Basic benefits" means the minimum benefits established by the plan board under ss. 635.21 and 635.23 (1) (a), and includes all health insurance mandates to the extent determined by the plan board under s. 635.23 (1) (b).

(1c) "Dependent" has the meaning given in s. 635.02 (3c).

(1m) "Eligible employe" has the meaning given in s. 635.02 (3f).

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

(5) "Health care provider" has the meaning given in s. 146.81 (1).

(5m) "Health insurance mandate" has the meaning given in s. 601.423 (1).

(10) "Plan" means the health insurance plan for individuals employed by small employers that is created under s. 635.21 and that consists of a policy under this subchapter containing the basic benefits.

(11) "Plan board" means the small employer insurance board.

(12) "Small employer" means any of the following:

(a) An individual, firm, corporation, partnership, limited liability company or association that is actively engaged in a business enterprise in this state, including a farm business, and that employs in this state not fewer than 2 nor more than 25 eligible employes. In determining the number of eligible employes, employers that are affiliated, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

(b) A village or town that employs not fewer than 2 nor more than 10 eligible employes and that has not provided health insurance coverage to its eligible employes at any time during the past 12 months.

(13) "Small employer insurer" has the meaning given in s. 635.02 (8).

History: 1991 a. 250; 1993 a. 112.

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

History: 1991 a. 250.

635.23 Duties of plan board. (1) The plan board shall:

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

(b) By rule establish the extent to which the plan shall comply with the health insurance mandates, without elimination of any of those mandates.

(c) By rule formulate minimum benefit standards for policies providing the basic benefits.

(d) By rule establish employer eligibility requirements for participation in the plan.

(dm) By rule establish deductibles, copayment and maximum payment requirements for policies providing the basic benefits.

(dp) By rule determine whether employers participating in the plan may impose a probationary or waiting period on employes who become eligible for coverage after the commencement of the employer's coverage. The plan board may not allow for a probationary or waiting period that exceeds 90 days.

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

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

1. The number of small employers participating in the plan.

2. The number of employes and dependents participating in the plan.

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

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

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

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

(3) All final decisions of the plan board under this section concerning the formulation, supervision and modification of the plan shall be adopted by a vote of not less than 8 members of the plan board's current voting membership.

(4) In the formulation of the plan, for the purpose of cost containment the plan board shall encourage the use, to the extent possible, of the services of health care providers other than physicians. The plan board shall report any recommendations on ways to encourage the use of the services of health care providers other than physicians to the chief clerk of each house of the legislature for distribution under s. 13.172 (3) to the standing committees with jurisdiction over health insurance.

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

History: 1991 a. 250.

635.25 Eligibility for participation in plan. (1) EMPLOYERS. (a) To be eligible to participate in the plan by purchasing a policy under this subchapter containing the basic benefits, an employer:

1. Must be a small employer; and

2. Must comply with any other eligibility requirements specified by the plan board.

(b) Except as provided in ss. 645.43 and 646.35, an employer that purchases a policy under this subchapter containing the basic

benefits and that ceases to be eligible to participate in the plan during a policy period shall retain coverage under the plan to the end of the policy period.

(1m) Notwithstanding sub. (1), an employer is not eligible to participate in the plan if all of the individuals to be covered under the plan may be covered by a single policy providing individual or family coverage.

(2) EMPLOYES AND DEPENDENTS. (a) All eligible employes of an eligible employer that participates in the plan are eligible for coverage under the plan, subject to the policy terms.

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

History: 1991 a. 250.

635.254 Employer premium contribution. (1) An employer that participates in the plan shall pay a premium contribution of not less than 50% of the premium rate on behalf of an eligible employe with individual coverage and not less than 40% of the premium rate on behalf of an eligible employe with family coverage.

(2) An employer under sub. (1) shall withhold from the earnings of an employe with coverage under the plan the amount of premium not contributed by the employer under sub. (1).

(3) For an eligible employe who obtains coverage under the health insurance risk−sharing plan under s. 619.12 (2) (e) 2., an employer under sub. (1) shall pay a premium contribution to the health insurance risk−sharing plan that is equal to the amount that the employer would pay on behalf of the employe for coverage under the plan under this subchapter.

History: 1991 a. 250.

635.26 Guaranteed issue. (1) Except as provided in subs. (2m) to (4), a small employer insurer shall provide coverage under the plan, regardless of health status or claims experience, to an eligible employer and to all of its eligible employes and their dependents if all of the following apply:

(a) The employer agrees to pay the premium required for coverage under the plan.

(b) The employer agrees to comply with all other plan provisions that apply generally to a policyholder or an insured without regard to health status or claims experience.

NOTE: Sub. (1) is shown as affected eff. 5−1−97 by 1995 Wis. Act 289. Prior to 5−1−97 it reads:

(1) (a) Except as provided in subs. (2m) to (4), a small employer insurer shall provide coverage under the plan, regardless of health status or claims experience, to an eligible employer and to all of its eligible employes and their dependents if all of the following apply:

1. The employer agrees to pay the premium required for coverage under the plan.

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

(b) Except as provided in subs. (2m) to (4), a small employer insurer shall provide coverage under the plan, regardless of health status or claims experience, to an eligible employe who becomes eligible for coverage after the commencement of the employer's coverage, and to the eligible employe's dependents, if all of the following apply:

1. The employe applies for coverage under the plan before the expiration of any applicable enrollment period, if any, required under the plan.

2. The employer agrees to pay the premium required for coverage of the employe under the plan.

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

(1s) Nothing in sub. (1) prohibits a small employer insurer that provides coverage under sub. (1) from imposing preexisting condition provisions, waiting period requirements, or other provisions or requirements related to health status or claims experience, that are permitted or required under the plan.

(2) A small employer insurer that provides coverage under sub. (1) may impose payment security provisions reasonably related to the risk covered.

(2m) Nothing in sub. (1) requires a small employer insurer to issue coverage that the small employer insurer is not authorized to issue under its bylaws, charter or certificate of incorporation or authority.

(3) Subsection (1) does not apply to a small employer insurer if the commissioner determines that any of the following applies:

(a) It is inequitable to apply sub. (1) to the small employer insurer due to its disproportionate share of groups with high claims experience.

(b) It is in the public interest to exempt the small employer insurer from the requirement under sub. (1) because the small employer insurer is in financially hazardous condition.

(4) A small employer insurer that offers health insurance coverage exclusively to a single category or limited categories of eligible employers is required to comply with sub. (1) only as to that single category or those limited categories of eligible employers.

(6) The commissioner may adopt rules that are reasonably necessary to accomplish the purpose of this section.

History: 1991 a. 250; 1995 a. 289.

635.272 Payments to health care providers. (1) CONTRACTING HEALTH CARE PROVIDERS. A health care provider that contracts with a small employer insurer to provide services to individuals with coverage under the plan shall accept amounts payable under the contract for the basic benefits as payment in full for those services.

(2) SELECTED PROVIDERS. Nothing in sub. (1) supersedes s. 609.05.

History: 1991 a. 250.

635.28 Liability of state and plan board. Neither the state nor the plan board is liable for any obligation arising under the plan. Plan board members are immune from civil liability for acts or omissions while performing their duties under this subchapter.

History: 1991 a. 250.

635.29 Exemption from required coverage. The health insurance mandates apply to the plan under this subchapter only to the extent determined by the plan board under s. 635.23 (1) (b).

History: 1991 a. 250.

635.31 Chapters 600 to 655 applicable. Except as otherwise provided in this subchapter, the plan shall comply with and be administered in compliance with chs. 600 to 655.

History: 1991 a. 250.