CR 93-42

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

I, Josephine W. Musser, Commissioner of Insurance and custodian of the official records of this office, certify that the attached rule-making order affecting Chapter Ins 8, Wis. Adm. Code, relating to underwriting and marketing standards for small employer health insurance policies and eligibility for coverage under the health insurance risk-sharing plan, was issued by this office on October 13, 1993.

I further certify that I have compared this copy with the original on file in this office and that it is a true copy of the whole of the original.

Dated at Madison, Wisconsin, this 13 day of October 1993.

Josephine W. Musser
Commissioner of Insurance

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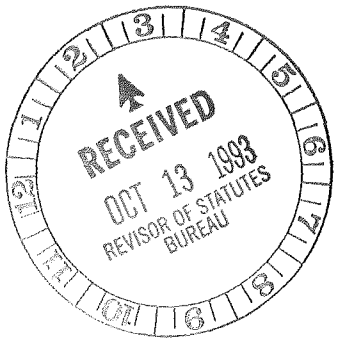

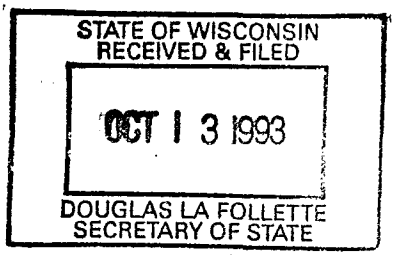

ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

RENUMBERING, RENUMBERING AND AMENDING, AMENDING,

AND CREATING A RULE

To renumber Ins 8.42 (1) to (2) and 8.44 (2); to renumber and amend Ins 8.42 (3) (b) and (c) and 18.05 (2) (c); to amend Ins 3.28 (6) (a), 3.31 (3) (a) 4 a., 8.40, 8.44 (1), 8.46 (2), 8.52 (3) (d) (intro.), 8.54 (4) (title) and (a) to (c) and 18.05 (1); and to create Ins 6.80 (2) (b) 10, 8.42 (1), (3) to (7), (9) (d) and (10) to (13), 8.44 (2), 8.59 to 8.69, 8.78 (3) (c) and 18.05 (2m) (title), (a) (title) and (b), relating to underwriting and marketing standards for small employer health insurance policies and eligibility for coverage under the health insurance risk sharing plan.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: 601.41 (3), 619.123, 628.34 (12), 635.05, 635.18 (8), and 635.26 (6), Stats.

Statutes interpreted: 619.12 (2) (e), 628.10, 628.34 (1), (3), (5), (7) and (11), 628.38, 631.09, 631.20 and ch. 635, Stats.

This rule establishes standards for marketing and underwriting practices of insurers who sell health insurance policies to small employers or

employes of small employers. The rule requires insurers to cover all the individuals who are employed by, or are dependents of employes of, a small employer, with few exceptions, and regulates the small employer health insurance market to ensure that each insurer provides a basic health insurance policy to a fair share of all the small employer groups who normally could not obtain coverage because of the poor health of one or more of their employes or employe dependents. The rule applies to a policy sold to an employer, or employes of an employer, who has 2 to 25 full-time employes and is in business in this state.

The rule establishes marketing and underwriting standards which are intended to prevent insurers and insurance agents from circumventing the purpose of these underwriting restrictions. It imposes standards for sale of a guarantee issue basic health benefit plan. It adopts guidelines for determining whether these restrictions continue to apply when the employer moves out of state or ceases to be a small employer. Finally, it regulates under what circumstances individuals in a small employer group may enroll, or continue to be enrolled in coverage under the health insurance risk sharing plan ("HIRSP"), rather than in a health insurance policy issued to the small employer.

UNDERWRITING RESTRICTIONS IN THE SMALL EMPLOYER MARKET

The rule restricts the ability of insurers to not provide coverage to small employer employes or dependents during the initial enrollment before a policy is issued, when a new employe is hired and when an employe or dependent applies after an open enrollment period has been concluded. The rule requires insurers to also make a one-time offer of coverage to any employe or dependent who was rejected for coverage by the current or a previous insurer prior to May 12, 1992, the effective date of the law this rule interprets.

A. INITIAL ENROLLMENT PERIOD.

Insurers must allow all of a small employer's full-time employes and their dependents to enroll in coverage when a small employer first applies for a health insurance policy. The insurer must provide the same coverage to all of those individuals. The insurer may not apply riders, exclusions, or limits that are directed at particular individuals. The insurer may offer, or participate in an offer, to the employes of an unrestricted choice among 2 or more polices.

The rule also includes provisions which are intended to prevent coercion, "steering," or manipulation of an employe to decline coverage under a health insurance policy. Generally, waivers of coverage must be voluntary (see the discussion below under "WAIVERS AND UNDERWRITING RECORDS").

The rule prohibits an insurer from accepting a waiver of coverage during the initial enrollment period prior to issuance of a policy. An insurer may accept waivers during that period only from individuals who are:

1. Individuals who have relatively low incomes. An employe has a "low income" if the employe would have to pay more than 10% of the employe's annualized earnings from the employer for the insurance premium.

2. Individuals who are "healthy", that is do not have a health condition which would result in the insurer rejecting coverage or increasing premium for the group.

3. Individuals who have other coverage, other than coverage under HIRSP.

4. Individuals who have severe and chronic or long-lasting physical or mental illnesses or disabilities, are covered under HIRSP and who otherwise would be covered only by the basic health benefit plan.

B. NEWLY HIRED EMPLOYES

Insurers must allow new full-time employes, and dependents of new full-time employes, to enroll in coverage under the small employer's health insurance policy. The insurer must provide the same coverage to all of those individuals. The insurer may not apply riders, exclusions, or limits that are directed at particular individuals. The insurer must offer to the newly hired employes an unrestricted choice among any policies offered during the original initial enrollment period.

An insurer may accept a voluntary waiver of coverage from any newly hired employe or a dependent, except the insurer may not accept a waiver from an individual who is covered under HIRSP unless the policy is a basic health benefit plan and the individual has a severe and chronic or long-lasting physical or mental illnesses or disability. An insurer must cover any newly hired employe or dependent who is covered under HIRSP. The individual is required by existing law to switch coverage from HIRSP to the employer's policy, unless the policy is a basic health benefit plan and certain conditions are met.

An insurer is required to apply "portability" to waive preexisting condition exclusions for any individual who is required to switch from HIRSP to the small employer policy. An insurer may permit an employer to impose no more than a 6-month probationary period before a newly hired employe is eligible for coverage under a policy.

C. EMPLOYES OR DEPENDENTS ENROLLED IN HIRSP WHEN THE EMPLOYER OBTAINS A STANDARD HEALTH INSURANCE POLICY

An individual may elect to obtain or retain coverage under HIRSP rather than under a small employer's policy only if the policy is the basic health benefit plan and if the individual has a severe and chronic or

long-lasting physical or mental illnesses or disability. Under the rule if the small employer subsequently obtains a standard health insurance policy the insurer must cover the individual who had been enrolled in HIRSP and the individual will cease to be eligible for coverage under HIRSP. The insurer is required to apply "portability" to waive preexisting condition exclusions for any such individual.

D. EMPLOYES REJECTED PRIOR TO PASSAGE OF THE SMALL EMPLOYER LAW

Prior to May 12, 1992, insurers were not subject to restrictions on excluding coverage of individuals in a small employer group. Effective May 12, 1992, or the first renewal date after May 12, 1992, insurers were subject to a law which requires them to offer coverage to all members of a small employer group. This rule implements that law for employes or dependents who were rejected by the current or a previous insurer for coverage prior to the application of the new law and who remain part of the group. Insurers are required to offer a one-time open enrollment under the policy to all of those individuals other than those who are currently covered under HIRSP.

The rule requires insurers to give notice to employers within 45 days of its effective date of the rule of the retroactive offer. Insurers must give at least 30 days' advance notice of the retroactive open enrollment period. Insurers must make reasonable efforts to ensure that employers give notice of the open enrollment period to their employes.

The open enrollment period must last for 90 days and preexisting condition exclusions are deemed met by the period since the original rejection and the date coverage is effective under this provision.

E. LATE ENROLLEES

An insurer is permitted to underwrite an employe or dependent who waives coverage under a small employer policy during an enrollment period and

who subsequently applies for coverage (a "late enrollee") only for the purpose of determining whether to impose a preexisting condition exclusion or a waiting period of up to 18 months.

The rule contains several exceptions to the general permission to apply an 18-month preexisting condition exclusion or waiting period to late enrollees. If the employe or dependent waives coverage because he or she had other qualifying coverage, but subsequently loses it for any reason, the employe or dependent may apply for coverage under the small employer's policy and must be accepted without imposition of an 18-month preexisting condition or waiting period. HIRSP is not considered qualifying coverage for this purpose unless the individual enrolled in HIRSP as an alternative to coverage under a basic health benefit plan. Similarly a late enrollee spouse or dependent must be enrolled under a policy without application of an 18-month preexisting condition or waiting period if a court orders that the spouse or dependent be covered under the policy.

Insurers are not required to provide coverage as "late enrollees" to individuals who are enrolled in HIRSP and who declined coverage during an enrollment period which occurs prior to the effective date of this rule.

F. RETROACTIVE COVERAGE AS LATE ENROLLEES

Insurers are required to treat as "late enrollees" those individuals who declined coverage under a small employer's policy prior to, on, or after the effective date of the rule unless the individual is covered under HIRSP on the effective date of the rule.

G. PREMIUMS AND RIDERS

Insurers remain subject to the rate restrictions imposed on rates for small employer policies. This rule continues to limit any increase in rate because an insurer is required to cover an individual as a newly hired employe or dependent or late enrollee or in the one-time open enrollment, to the

remaining increment permitted under the rate rule for the policy year. Rates may be further adjusted when the policy renews.

The rule prohibits insurers from applying exclusions or riders to restrict benefits for particular individuals in small employer groups. Insurers are required to delete any exclusions or riders which were imposed prior to May 12, 1992, the date the law was enacted which prohibits them.

WAIVERS AND UNDERWRITING RECORDS

An insurer may exclude an individual from coverage under a small employer policy, if it is otherwise permitted, only if the individual voluntarily waives coverage. If the insurer or its agent reasonably should know that the employer has unfairly induced or pressured an individual to waive coverage, the insurer may not accept the waiver. Agents are required to report any information that indicates an individual is being pressured or unfairly induced to waive coverage.

Insurers must obtain signed waivers of coverage which contain certain prescribed information. Waivers of enrollment during an initial enrollment period after issuance of a policy must be accompanied by underwriting information sufficient for the insurer to determine whether the insurer may accept the waiver.

An insurer must obtain a list of all individuals in a small employer group and must maintain in its records all of the information it is required to collect and the waivers.

PORTABILITY

The rule clarifies which policies qualify for the purpose of "portability." "Portability" refers to the law which requires insurers to consider preexisting condition exclusions to be met to the extent the covered individual was subject to a similar provision, and benefits were payable,

under previous coverage. "Portability" is most often applicable when an employe switches employers and therefore health insurance coverage.

The rule generally provides that portability applies if the previous coverage is, taken as a whole, at least as generous as the basic health benefit plan. Insurers are required to obtain from the previous insurer the information necessary to apply portability standards.

New entrants and individuals enrolled during an initial enrollment period who were previously enrolled in HIRSP are entitled to portability under the small employer policy.

The rule also provides for the implementation of portability between a health insurance policy and a small employer health insurance policy. The benefits the basic health benefit plan must provide are prescribed by a rule which was effective July 1, 1993. After that date small employer insurers must give portability between any small employer policy and any previous "qualifying coverage" which provides benefits at least as generous as the basic health benefit plan. The rule requires small employer insurers to administratively do that for all policies in force as of July 1, 1993, for any individual who is first covered under the small employer policy on or after July 1. Small employer insurers are required to include a provision in their small employer polices implementing this aspect of portability for all policies issued or renewed after November 1, 1993.

FAIR MARKETING STANDARDS

Insurers are required to follow certain procedures for the sale of the basic health benefit plan, including:

1. An offer of the plan to any small employer who applies for any form of health insurance coverage and disclosure of certain information relating to enrollment in HIRSP.

2. Timely price quotes.

3. Offer of the plan if the insurer denies an application for another policy.

4. A toll-free telephone information line which need not be dedicated.

5. Association or trust membership conditions may not be used to circumvent the mandatory marketing of the small employer policies.

6. Purchase of small employer health policies may not be conditioned on purchase or inclusion of other forms of insurance coverage.

7. Collection of information to establish whether the small employer health insurance restrictions apply to a particular employer.

8. Prohibiting agents from giving advice to a small employer regarding underwriting unless the advise is based on a specific review and determination by the insurer after the small employer submits an application.

9. Prohibiting limiting marketing of the basic health benefit plan or other small employer health policies to particular market segments unless the commissioner has given prior written approval. The rule also generally requires insurers to market at least one policy other than the basic health benefit plan to each segment of the market. HMO insurers and other insurers that restrict themselves to offering only HMO or preferred provider plans may limit their marketing to their service areas. Other insurers may limit marketing to selected areas only if they can clearly establish that the areas are selected for reasons other than favorable demographic characteristics.

10. Prohibiting insurers from limiting their marketing to small employers of a certain size. The rule permits insurers to continue existing marketing practices of marketing to only certain size small employers but only until February 1, 1995, and only if the insurer issues the basic health benefit plan on request to small employers regardless of size.

MARKET SHARE STANDARDS

The rule requires each insurer to issue a fair share of the number of basic health benefit plans issued to small employer groups with members who have adverse health conditions. The rule establishes market share ratios which each insurer must comply with unless the insurer can demonstrate that it is not in compliance for reasons not within its control. The rule requires quarterly reporting through calendar year 1995 and annual reporting.

HEALTH INSURANCE RISK-SHARING PLAN

A. HIRSP ELIGIBILITY UNDER THE BASIC HEALTH BENEFIT PLAN

The law governing HIRSP disqualifies from coverage under HIRSP those individuals who are eligible for coverage under an employer health insurance policy or self-funded plan. The law has an exception for individuals who have severe and chronic or long-lasting physical or mental illnesses or disabilities and who otherwise would be covered only by the basic health benefit plan.

This rule establishes the procedure for applying for coverage under HIRSP under that exception. It permits the insurer that issued the basic health benefit plan to contest allowing an individual into HIRSP under this exception.

B. REQUIRED DISENROLLMENT FROM HIRSP

Since the rule specifies when individuals must be covered under small employer policies, it also effectively determines whether an individual must be excluded from coverage under HIRSP under the statutory eligibility criteria. Generally, an individual will be terminated from coverage under HIRSP and required to enroll in coverage under a small employer policy unless:

1. The individual has a severe and chronic or long-lasting physical or mental illness or disability and the small employer policy is the guarantee issue basic health benefit plan.

2. The individual is covered under HIRSP on the effective date of this rule, except the individual will be required to disenroll in HIRSP and enroll in a small employer policy if:

a. The individual becomes eligible under a small employer policy after the effective date of the rule as a newly hired employe or dependent of a newly hired employe, but not if the individual may remain in HIRSP under paragraph 1;

b. The individual's small employer switches small employer policies and a new initial enrollment period is held, but not if the individual may remain in HIRSP under paragraph 1.

DEFINITIONS AND SUBTERFUGE

The rule makes it clear that the small employer insurance law may not be circumvented by purporting to sell individual policies or coverage under an association group policy purportedly other than through the employer.

Insurers are required to give certain warnings in renewal or termination of a small employer policy and a "grace" period of coverage for small employers who may lose the protection of the law because of participation requirements. Insurers are also required to inform small employers that they will lose the protection of the small employer law if the size of their workforce changes and they no longer qualify as small employers.

PARTICIPATION REQUIREMENTS

The rule makes it clear that small employer insurers may impose participation requirements but only according to a schedule or a percentage requirement which approximates not more than a 70% requirement.

EFFECTIVE DATE

This rule takes effect on the first day of the third month commencing after its publication, except the requirement to conduct a one-time open

enrollment and rules relating to portability takes effect on the first day of the first month commencing after its publication.

SECTION 1. Ins 3.28 (6) (a) is amended to read:

Ins 3.28 (6) (a) If the existence of a disease or physical condition is duly disclosed in the application for coverage in response to the questions therein, the insurer shall not use the pre-existing defense, under coverage providing such a defense, to deny benefits for such disease or condition unless such disease or condition is excluded from coverage by name or specific description effective on the date of loss. This paragraph does not apply to a preexisting condition exclusion permitted under s. 635.17 (1), Stats.

SECTION 2. Ins 3.31 (3) (a) 4. a is amended to read:

Ins 3.31 (3) (a) 4. a. If the existence of a disease or physical condition was duly disclosed in the enrollment form for coverage in response to the questions therein, the insurer shall not use the preexisting defense, under coverage providing such a defense, to deny benefits for such disease or condition unless such disease or condition is excluded from coverage by name or specific description effective on the date of loss. This paragraph does not apply to a preexisting condition exclusion permitted under s. 635.17 (1), Stats.

SECTION 3. Ins 6.80 (2) (b) 10 is created to read:

Ins 6.80 (2) (b) 10. ss. Ins 8.65 (4) and 8.69 (6) apply to small employer insurers.

SECTION 4. Ins 8.40 is amended to read:

Ins 8.40 PURPOSE. This subchapter interprets and implements ~~subch. I of~~ ch. 635, Stats., and s. 619.12 (2) (e), Stats.

SECTION 5. Ins 8.42 (1) to (3) are renumbered Ins 8.42 (2), (8) and (9), respectively, and s. Ins 8.42 (9) (b) and (c), as renumbered, are amended to read:

Ins 8.42 (9) (b) An individual health benefit plan, including, but not limited to, an individual health benefit plan which is intended or designed to supplement a basic health benefit plan, issued by ~~a small employer~~ an insurer to an eligible employe if 3 or more eligible employes of the same small employer apply for the coverage or were intentionally excluded from applying for reasons related to their health, ~~where premium is collected through a direct or indirect arrangement with the small employer~~ and the individual health benefit plan is in fact, or in substance, sold to, or through the active cooperation of, the small employer, including but not limited to circumstances where:

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

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

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

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

(c) ~~In the case of a~~ For a health benefit plan that provides coverage ~~for more than one employer~~ through a trust or association, ~~the~~ a certificate or other evidence of coverage, including, but not limited to, coverage intended or designed to supplement a basic health benefit plan, issued to an individual small employer or in fact or substance, sold to, or through the

active cooperation of, the small employer, including but not limited to circumstances where:

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

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

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

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

SECTION 6. Ins 8.42 (1), (3) to (7), (9) (d) and (10) to (13) are created to read:

Ins 8.42 (1) "Basic market share ratio" means the ratio of the number of risk characteristic basic health benefit plans in force to the total number of basic health benefit plans in force.

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

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

(a) Did not request coverage during an enrollment period under a basic health benefit plan, is covered under the plan established under

subch. II of ch. 619, Stats., under s. 619.12 (2) (e) 2, Stats., and has not terminated eligibility for coverage under the plan established under subch. II of ch. 619, Stats.; or

(b) Did not request coverage during an enrollment period for a policy other than a basic health benefit plan which commenced prior to the effective date of this rule [revisor inserts date] and who was covered during the enrollment period under the plan established under subch. II of ch. 619, Stats.; or

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

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

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

(7) "New entrant" means an eligible employe, or the dependent of an eligible employe, who:

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

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

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

1. Is covered under qualifying coverage during the enrollment period and the qualifying coverage is not the plan established under subch. II of ch. 619, Stats., or, if it is the plan established under subch. II of ch. 619, Stats., it is obtained under s. 619.12 (2) (e) 2, Stats.;

2. Subsequently, and on or after the effective date of this rule [revisor inserts date] loses coverage under the qualifying coverage; and

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

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

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

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

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

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

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

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

insurer, and continued to be and is an eligible employe, or dependent of an eligible employe, of the small employer. "Underwritten individual" does not include a person who is covered under the plan established under subch. II of ch. 619, Stats., on the effective date of this rule [revisor inserts date].

SECTION 7. Ins 8.44 (1) is amended to read:

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

SECTION 8. Ins 8.44 (2) is renumbered Ins 8.44 (3).

SECTION 9. Ins 8.44 (2) is created to read:

Ins 8.44 (2) A small employer insurer shall notify each employer in writing when a policy is issued that if the employer employes less than 2 or more than 25 eligible employes during at least 50% of the number of weeks in any 12-month period, or moves the business enterprise outside this state, the protections provided under subch. I of ch. 635, Stats., and this subchapter will cease to apply to the employer on renewal of its health benefit plan.

SECTION 9m. Ins 8.46 (2) is amended to read:

Ins 8.46 (2) A statement of the minimum number of eligible employes required in order to keep the policy in effect, expressed either as an ~~absolute number~~ a schedule or as a percentage of eligible employes or both. The small employer insurer shall state the method for determining the minimum number required ~~shall be stated~~ in the policy or employer agreement. For the purpose of this subsection "eligible employe" does not include any person who has continued coverage under s. 632.897 (2) (b) 2, Stats., under a small employer's group policy and the number of individuals in a group shall not

include individuals with other qualifying coverage except as permitted under s. 635.17 (2) (c) 2, Stats. A small employer insurer may not impose more stringent requirements than the following:

1. For a small employer with more than 10 eligible employes, 70% of the group.

2. For a small employer with 10 eligible employes, 6 eligible employes.

3. For a small employer with 8 or 9 eligible employes, 5 eligible employes.

4. For a small employer with 7 eligible employes, 4 eligible employes.

5. For a small employer with 5 or 6 eligible employes, 3 eligible employes.

6. For a small employer with 2 to 4 eligible employes, 2 eligible employes.

SECTION 10. Ins 8.52 (3) (d) (intro.) is amended to read:

Ins 8.52 (3) (d) (intro.) For a rate change ~~due to a change in the small employer's census~~ made before the end of the policy term due to the addition of a new entrant, late enrollee, underwritten individual or a new dependent of an insured employe, par. (c) applies, except that:

SECTION 10m. Ins 8.54 (4) (title) and (a) to (c) are amended to read:

Ins 8.54 (4) (title) NONRENEWAL OR TERMINATION BASED ON PARTICIPATION REQUIREMENTS. (a) A small employer insurer that intends to nonrenew a policy or terminate a policy under s. 635.07 (1) (d), Stats., because the number of eligible employes is less than the number required to keep the policy in force shall do all of the following:

1. Notify the small employer of its intent to nonrenew or terminate and the reason for the nonrenewal or termination. The notice shall be given

as required under s. 631.36, Stats., for a nonrenewal or at least 20 days before a termination date for a termination.

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

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

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

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

SECTION 11. Ins 8.59 to 8.69 are created to read:

Ins 8.59 SMALL EMPLOYER INSURERS SHALL OFFER AN INITIAL ENROLLMENT PERIOD TO ALL MEMBERS OF SMALL EMPLOYER GROUPS; RIDERS AND DISCRIMINATORY COVERAGE ARE PROHIBITED. (1) A small employer insurer that offers a policy shall provide an initial enrollment period during which each eligible employe and dependent of an eligible employe is entitled to enroll in coverage under the policy.

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

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

(a) The enrollment period is simultaneous for all the policies;

(b) The eligible employe may choose any one of the offered policies; and

(c) All the policies offered provide benefits similar to or exceeding the benefits provided under the basic health benefit plan as determined under s. Ins 8.66 (1).

(4) A small employer insurer shall treat coverage under the plan established under subch. II of ch. 619, Stats., as qualifying coverage for all individuals who enroll during the initial enrollment period, for the purpose of applying s. 635.17 (1) (b), Stats., regardless of the duration of the coverage under the plan.

Ins 8.60 A SMALL EMPLOYER INSURER MAY ACCEPT AN EMPLOYE'S OR DEPENDENT'S WAIVER OF COVERAGE DURING AN INITIAL ENROLLMENT PERIOD ONLY UNDER LIMITED CONDITIONS. (1) A small employer insurer may not issue a policy unless during the initial enrollment period all the eligible employes and dependents of eligible employes elect and are provided coverage under the policy, except a small employer insurer may permit an individual to decline coverage in the initial enrollment period if the small employer insurer determines:

(a) The individual has coverage under a health benefit plan or other health benefit arrangement, other than the plan established under subch. II of ch. 619, Stats., that provides benefits similar to or exceeding benefits provided under the basic health benefit plan as determined under s. Ins 8.66 (1);

(b) The individual elected coverage under another policy during an enrollment period permitted under s. Ins 8.59 (3);

(c) The individual does not have a risk characteristic or other attribute that would be the sole cause for the small employer insurer to make a decision with respect to premiums or eligibility for a policy that is adverse to the small employer;

(d) The individual is not enrolled in the plan established under subch. II of ch. 619, Stats., and the annualized premium contribution to be paid by the eligible employe on behalf of the employe or the dependent of the employe would exceed 10% of the annualized gross earnings of the eligible employe from the employer; or

(e) The policy that is issued is the basic health benefit plan, the individual is, or is reasonably expected to be, covered under the plan established under subch. II of ch. 619, Stats., under s. 619.12 (2) (e) 2, Stats., and the individual is in fact covered under the plan established under ch. 619, Stats., effective not later than the effective date of the basic health benefit plan policy.

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

Ins 8.61 SMALL EMPLOYER INSURERS SHALL OFFER COVERAGE TO NEW ENTRANTS. (1) A small employer insurer shall provide under a policy for an enrollment period during which a new entrant is entitled to enroll in coverage under the policy. The small employer insurer shall provide an enrollment period under a policy of at least 30 days after the date the new entrant is notified of the opportunity to enroll. A small employer insurer which offers more than one policy in the initial enrollment period under s. Ins 8.59 (3)

shall offer the new entrant the same choice of policies during the new entrant's enrollment period.

(2) A small employer insurer may not accept waiver of coverage under a policy from a new entrant who is currently covered under the plan established under subch. II of ch. 619, Stats., and shall provide coverage under the policy to the new entrant, unless the policy is a basic health benefit plan and the new entrant is permitted to continue coverage under the plan established under subch. II of ch. 619, Stats., under s. 619.12 (2) (e) 2, Stats.

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

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

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

(6) A small employer insurer shall treat coverage under the plan established under subch. II of ch. 619, Stats., as qualifying coverage for all new entrants for the purpose of applying s. 635.17 (1) (b), Stats., regardless of the duration of the coverage under the plan.

Ins 8.62 SMALL EMPLOYER INSURERS SHALL OFFER AN OPEN ENROLLMENT FOR INDIVIDUALS EXCLUDED PRIOR TO ENACTMENT OR APPLICATION OF THE SMALL EMPLOYER HEALTH INSURANCE LAW. (1) A small employer insurer shall provide an enrollment period during which underwritten individuals who were excluded or denied coverage prior to the law's effective date are entitled to enroll in

coverage under the policy currently held by the small employer. Notice of the enrollment period shall given as required under sub. (4).

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

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

(a) It shall commence no later than 45 days after the effective date of this section [revisor inserts date] and shall last for a period of at least 90 days.

(b) Underwritten individuals who are provided an opportunity to enroll under this section shall be treated as new entrants.

(c) The terms of coverage offered to an underwritten individual under sub. (1) may exclude coverage for preexisting medical conditions only if the policy currently held by the small employer contains such an exclusion, the exclusion complies with s. 635.17 (1), Stats., and the exclusion period is reduced by the number of days between the date the individual was excluded or denied coverage and the date coverage is provided to the individual under this section.

(4) A small employer insurer shall provide written notice of the right to enroll under this section to each small employer insured under a policy offered by the insurer. The notice shall be mailed at least 30 days before commencement of the enrollment period and shall clearly describe the rights granted under this section and the process for enrollment of the underwritten individuals in the policy. The insurer shall provide the

employer with sufficient copies of the notice to distribute to each eligible employe and shall ask the employer to promptly distribute a copy to each eligible employe. The small employer insurer shall make reasonable efforts to obtain from the small employer certification that the notice was promptly distributed to all eligible employes.

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

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

Ins 8.63 SMALL EMPLOYER INSURERS SHALL OFFER COVERAGE TO LATE ENROLLEES. (1) A small employer insurer shall provide under a policy for an enrollment period during which a late enrollee is entitled to enroll in coverage under the policy. The small employer insurer shall provide an enrollment period of at least 30 days after the date the late enrollee requests coverage and is notified of the opportunity to enroll.

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

condition exclusion under s. 635.17 (1), Stats., in addition to an exclusion permitted under this subsection.

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

Ins 8.64 SMALL EMPLOYER INSURERS MAY NOT PARTICIPATE WITH A SMALL EMPLOYER TO COERCE, OR DISCRIMINATE AMONG, ELIGIBLE EMPLOYES OR DEPENDENTS. (1) A small employer insurer may not accept a waiver of coverage, if the insurer, or an insurance intermediary for the insurer, reasonably should know that the small employer pressured or unfairly induced the eligible employe or dependent of an eligible employe to decline coverage due to the individual's risk characteristics.

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

Ins 8.65 A SMALL EMPLOYER INSURER SHALL REQUIRE SMALL EMPLOYERS TO PROVIDE DOCUMENTATION TO ESTABLISH THAT WAIVERS OF COVERAGE ARE VOLUNTARY AND PERMITTED. (1) A small employer insurer shall require each small employer that applies for a policy, as part of the application process, to provide a complete list of eligible employes and dependents of eligible employes of the small employer. The small employer insurer shall require the small employer to provide appropriate supporting documentation, such as the state unemployment or worker's compensation quarterly reporting forms, to verify the information required under this subsection.

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

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

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

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

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

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

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

Ins 8.66 QUALIFYING COVERAGE FOR PORTABILITY AND LATE ENROLLEES; TRANSITION. (1) For the purpose of determining whether a health benefit plan or other health benefit arrangement is qualifying coverage under s. 635.17, Stats., or under this subchapter:

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

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

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

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

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

(2) For the purposes of s. 635.17 (1) (b), Stats., an individual has previous qualifying coverage with respect to a particular service if the previous policy, certificate or other benefit arrangement covering the individual was qualifying coverage and provided any benefit with respect to the service.

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

employer insurer shall contact the source of previous or existing coverage to resolve any questions about the benefits or limitations related to the previous or existing coverage.

(4) No small employer insurer may renew or issue a policy after November 30, 1993, unless the policy includes a provision complying with s. 635.17 (1) (b), Stats., as to qualifying coverage defined in s. 635.02 (5m) (b) and (c), Stats., in addition to qualifying coverage defined in s. 635.02 (5m) (a), Stats. An insurer shall administratively comply with s. 635.17 (1) (b), Stats., for all policies in force on or after July 1, 1993, with respect to qualifying coverage defined under s. 635.02 (5m) (b) and (c), Stats., for all individuals who commence coverage under a policy after June 30, 1993. All small employer insurers shall establish and disseminate policies and procedures designed to ensure compliance with this subsection by not later than the effective date of this subsection [revisor inserts date].

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

Ins 8.67 RESTRICTIVE RIDERS PROHIBITED. (1) A restrictive rider, endorsement or other provision that would violate s. 635.17 (3) (b), Stats., and that was in force on May 12, 1992, may not remain in force beyond the first renewal date of the policy and a small employer insurer shall delete the rider, endorsement or other provision after the law's effective date.

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

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

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

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

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

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

1. Files with the commissioner on or after the effective date of this rule [revisor inserts date], in the form prescribed by the commissioner, a request for approval to limit its marketing of policies;

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

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

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

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

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

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

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

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

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

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

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

(b) That an individual who would otherwise be covered under the basic health benefit plan and who has a severe and chronic or long-lasting physical or mental illness or disability may be eligible for coverage under the plan established under subch. II of ch. 619, Stats., under s. 619.12 (2) (e), Stats.

(c) That an individual described under par. (b) who elects to be covered under the plan established under subch. II of ch. 619, Stats., and who subsequently terminates coverage under the plan:

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

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

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

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

(4) A small employer insurer shall provide written notice of the information described under sub. (3) (a) to (c) to each small employer who applies for a basic health benefit plan within 10 working days of the date the small employer insurer receives the small employer's application. The small employer insurer shall provide the notice directly or through an authorized

insurance intermediary. The small employer insurer shall provide the employer with sufficient copies of the notice to distribute to each eligible employe and shall ask the employer to promptly distribute a copy to each eligible employe. The small employer insurer shall make reasonable efforts to obtain, within 20 business days after the small employer insurer issues a basic heath benefit plan to a small employer, certification that the small employer promptly distributed the notice to all eligible employes.

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

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

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

1. A general description of the benefits contained in each plan;

2. A price quote for each plan; and

3. Information describing how the small employer may enroll in the plan.

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

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

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

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

(a) The requirement is reasonable;

(b) The requirement is not intended to and does not discourage or prevent acceptance of small employers applying for the basic health benefit plan;

(c) The requirement is not related to the health status or claim experience of the small employer or employes or dependents of employes of small employers;

(d) The requirement is applied consistently to all small employers applying for coverage; and

(e) The small employer insurer permits all small employers who join the association or group to apply for a health benefit plan.

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

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

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

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

3. Whether or not the prospective policyholder, certificate holder or any prospective insured individual intends to treat the health benefit plan as

part of a plan or program under Section 162 [other than Section 162 (1)], Section 125 or Section 106 of the United States internal revenue code.

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

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

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

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

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

Ins 8.69 MINIMUM STANDARDS FOR MARKET SHARE OF BASIC HEALTH BENEFIT PLANS IN FORCE; EXEMPTION FROM GUARANTEE ISSUANCE OF THE BASIC HEALTH BENEFIT PLAN. (1) No small employer insurer may have a basic market share ratio which is significantly less than the basic market share ratio for all small employer insurers unless the insurer establishes by clear and convincing evidence that the reason the basic market share ratio is significantly less is because:

(a) Of a specific practice or condition that is beyond the control of the insurer; or

(b) The insurer uses risk characteristics to underwrite applications for policies to a substantially lesser extent than most other small employer insurers.

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

(a) Of a specific practice or condition that is beyond the control of the insurer; or

(b) The insurer uses risk characteristics to underwrite applications for policies to a substantially lesser extent than most other small employer insurers.

(3) For the purpose of this section:

(a) A small employer insurer's basic market share ratio is presumed to be significantly less than the basic market share ratio for all small employer insurers if the small employer insurer's basic market share ratio is less than a number equal to $q-2[q(1-q)/m)]^{1/2}$. For the purpose of this paragraph:

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

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

(b) A small employer insurer's market share ratio is presumed to be significantly less than the market share ratio for all small employer insurers if the small employer insurer's market share ratio is less than a number equal to $p-2[p(1-p)/n)]^{1/2}$. For the purpose of this paragraph:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) By March 1 of each year:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 12. Ins 8.78 (3) (c) is created to read:

Ins 8.78 (3) (c) Section Ins 8.63 (2) applies to an eligible employe or dependent who does not enroll in a small employer's plan within the period specified in par. (a) or (b).

SECTION 13. Ins 18.05 (1) is amended to read:

Ins 18.05 (1) CRITERIA. The administering carrier shall certify as eligible any resident as defined in s. 619.10 (9), Stats., upon written receipt from the plan applicant of evidence of any of the eligibility criteria set forth in s. 619.12 (1), Stats., or a physician certification meeting the requirements of sub. (2m) (b) that is accepted following the review process specified under s. 619.12 (2) (e) 2, Stats.

SECTION 14. Ins 18.05 (2) (c) is renumbered Ins 18.05 (2m) (a) and Ins 18.05 (2m) (a) (intro.), as renumbered, is amended to read:

Ins 18.05 (2m) (a) (intro.) Section 619.12 (2) (e) 1, Stats., does not preclude eligibility for coverage under the plan under any of the following conditions:

SECTION 15. Ins 18.05 (2m) (title) and (a) (title) are created to read:

Ins 18.05 (2m) (title) SPECIAL ELIGIBILITY REQUIREMENTS. (a) (title) Limited coverage under employer plan.

SECTION 16. Ins 18.05 (2m) (b) is created to read:

Ins 18.05 (2m) (b) Physician certification. 1. An applicant for coverage under the plan who believes he or she is eligible under s. 619.12 (2) (e) 2. a, Stats., shall submit with the application all of the following:

a. The name and address of the applicant's employer and the name and address of the insurer that provides the employer's small employer health insurance plan under subch. II of ch. 635, Stats.

b. A certification signed, not more than 30 days before the date of application, by a physician licensed under ch. 448, Stats., stating that the applicant has a severe and chronic or long-lasting physical or mental illness or disability.

2. a. Upon receipt of an application under subd. 1, the administering carrier shall notify the insurer named in subd. 1. a that it has the right, under s. 619.123, Stats., to submit information contesting or supporting the physician's certification within 5 working days after receipt of the notice. Only the insurer named in subd. 1. a has the right to support or contest the certification.

b. An insurer which does not respond within the time specified or notifies the administering carrier that it supports the physician's certification may not contest the certification. This does not limit the board's authority to review an application under s. 619.12 (2) (e) 2.

c. If the insurer contests the physician's certification, the administering carrier shall refer the application with the attached physician's certification and the insurer's written objection to the board.

d. The board shall make the final decision on the applicant's eligibility for the plan under s. 619.12 (2) (e) 2, Stats. The board may delegate the authority to make the decision to the administering carrier, or may delegate the authority to make the initial decision subject to a right of

the applicant or a contesting insurer to appeal an adverse decision to the board.

SECTION 17. EFFECTIVE DATE. This rule takes effect on the first day of the 3rd month commencing after its publication, except that ss. Ins 8.62 and 8.66 take effect on the first day of the first month commencing after its publication.

Dated at Madison, Wisconsin, this 13 day of October 1993.

Josephine W. Musser
Commissioner

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10/12/93