Chapter Ins 8

EMPLOYE WELFARE FUNDS; EMPLOYE BENEFIT PLAN ADMINISTRATORS; SMALL EMPLOYER HEALTH INSURANCE

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Note: Sections Ins 8.20 to 8.32 were created as emergency rules effective October, 1, 1991. Sections Ins 8.40 to 8.56 were created as emergency rules effective February 12, 1992.

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

pensation for necessary services and expenses rendered or incurred in connection with official duties in respect to the fund.

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

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

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

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

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

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

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

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

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

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

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

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

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

Ins 8.02 "Trust fund or other fund", definition. (1) A "trust fund or other fund" constituting an employe welfare fund subject to ch. 641,

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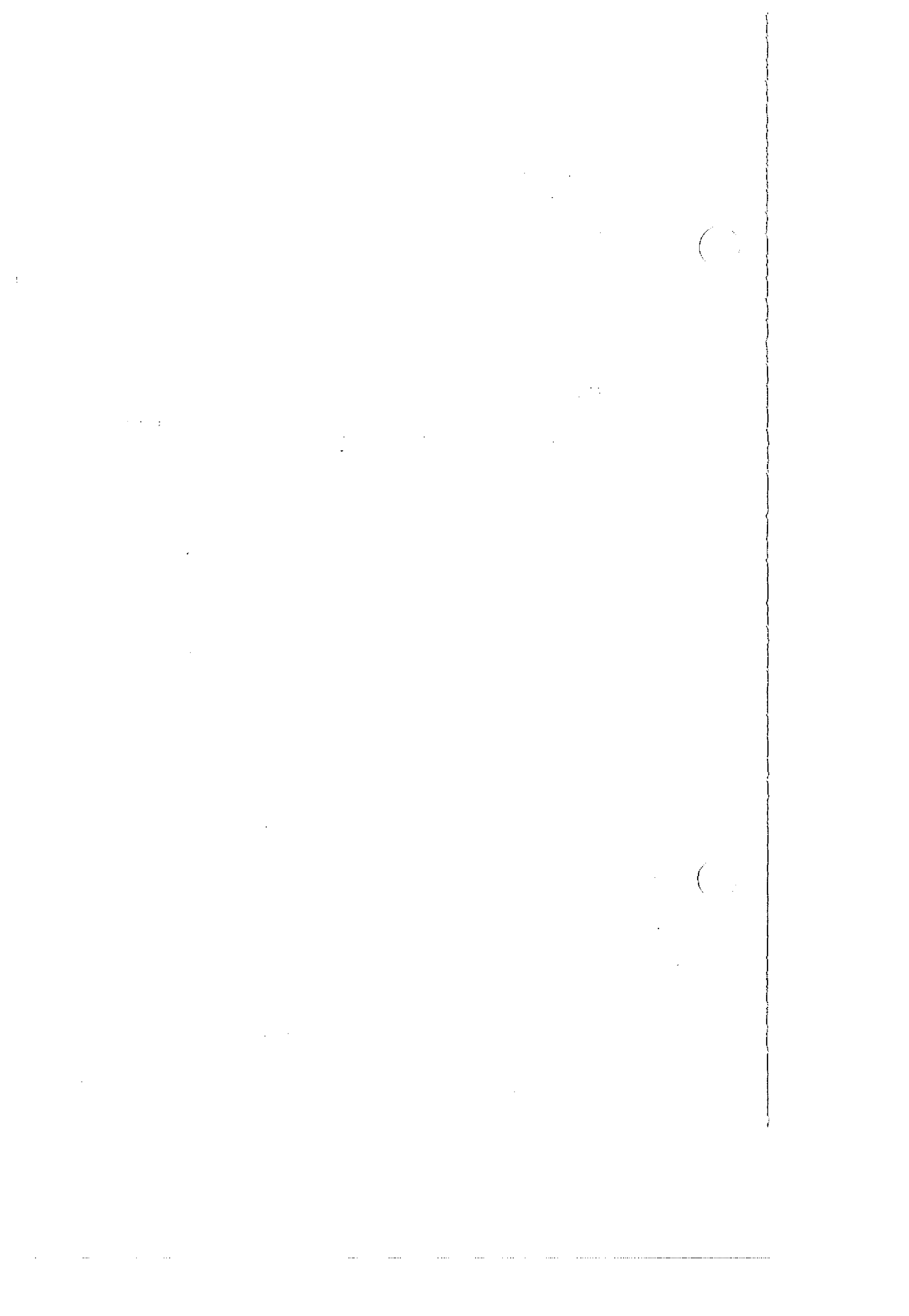

insurance regulatory agency in each state in which an affected insured individual resides. The notice shall include all of the following:

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

2. The date on which coverage will terminate.

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

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

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

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

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

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

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

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

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

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

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

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

Subchapter IV — Basic Health Benefit Plan For Small Employers

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

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

Ins 8.71 Definitions. (1) The definitions in ss. 635.02 and 635.20, Stats., apply to this subchapter.

(2) In this subchapter, "health care provider" means any of the following:

(a) A medical or osteopathic physician, podiatrist, physical therapist or physician's assistant licensed or certified under ch. 448, Stats.

(b) A psychologist licensed under ch. 445, Stats.

(c) A chiropractor licensed under ch. 446, Stats.

(d) A nurse midwife certified under s. 441.15, Stats.

(e) A nurse practitioner licensed under ch. 441, Stats.

(f) A nurse licensed under ch. 441, Stats., who is certified as a nurse anesthetist by the American association of nurse anesthetists.

(g) A dentist licensed under ch. 447, Stats.

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

Ins 8.72 Basic benefits. Subject to the limitations and restrictions under s. Ins 8.75 and copayments and coinsurance under s. Ins 8.77, each plan shall provide coverage for all of the following, if medically necessary:

(1) Professional services by a health care provider acting within the scope and limitations of his or her license or certificate or a person acting under the direction of a health care provider, including all of the following:

(a) Office, outpatient, inpatient and emergency room visits including treatment rendered during those visits.

(b) Surgical services including postoperative care following inpatient or outpatient surgery.

(c) Services of an assistant surgeon if necessary to perform surgery.

(d) Anesthesia services.

(2) Hospital care, including all of the following:

(a) Semi-private room, board and ancillary services and supplies that are generally provided to hospital inpatients.

(b) Confinement in an intensive care or coronary care unit of a hospital.

(c) Outpatient medical care and treatment.

(d) Medical care and treatment provided in a hospital emergency room.

(3) Medical care and treatment provided in an ambulatory surgery center, as defined in s. 49.45 (6r) (a) 1, Stats.

(4) Outpatient x-ray, laboratory and other diagnostic tests.

(5) Confinement in a skilled nursing home licensed under subch. I of ch. 50, Stats.

(6) Services provided by a home health agency licensed under s. 141.15, Stats.

(7) Care provided by a hospice licensed under subch. IV of ch. 50, Stats.

(8) Local ground licensed ambulance services.

(9) Physical therapy.

(10) Rental and purchase of durable medical equipment and supplies.

(11) Prescription drugs.

(12) Reconstructive surgery which is either of the following:

(a) Incidental to or following surgery necessitated by illness or injury.

(b) Caused by a congenital disease or anomaly of a covered dependent child which results in a functional defect.

(13) Sterilization.

(14) Maternity services including all of the following:

(a) Prenatal services normally associated with pregnancy.

(b) Delivery services normally associated with a vaginal or caesarean section delivery.

(c) Routine nursery care from the moment of birth until the infant is discharged from the hospital.

(15) Complications of pregnancy.

(16) Inpatient, outpatient and transitional treatment for nervous and mental disorders and alcoholism and other drug abuse, subject to s. Ins 8.75 (3).

(17) Preventive services appropriate to the age and sex of the covered person including all of the following:

(a) Routine physical examinations and health screening tests.

(b) Immunizations for poliomyelitis, diphtheria, pertussis, typhoid, measles, mumps and rubella.

(c) Vaccinations for hemophilus influenza, type B.

(d) Diphtheria and tetanus boosters.

(e) Influenza and pneumonia vaccinations.

(f) Tuberculosis skin tests.

(18) Organ transplants that are covered by medicare.

(19) Services provided by a dentist for the repair of accidental dental injuries.

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

Ins 8.73 Health insurance mandates. A plan shall comply with the health insurance mandates, as defined in s. 601.423, Stats., and may not exclude or limit coverage for any mandate except as provided in s. Ins 8.75 (3).

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

Ins 8.74 Policy title; term. (1) The policy form for a plan submitted to the office of the commissioner of insurance for approval under s. 631.20, Stats., shall be entitled "basic health benefit plan."

(2) The term period for plan coverage shall not be less than 12 months.

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

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

(2) ANNUAL MAXIMUM. The annual calendar year maximum benefit for a plan is $30,000 per insured individual. Charges for a hospitalization which extends from one calendar year to another shall be subject to the calendar year maximum for the year in which each charge was incurred and only one $100 copayment shall apply to the confinement.

(3) LIMITATION ON COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT. The annual calendar year benefit payable for treatment of a covered person for nervous and mental disorders and alcoholism and other drug abuse is $1,400. A plan may not apply the cost of outpatient prescription drugs used in the treatment of nervous and mental disorders or alcoholism or other drug abuse toward the annual limit specified in this subsection.

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

Ins 8.76 Policy terms; exclusions; limitations. (1) Except as otherwise provided in this subchapter, a plan's policy terms shall be defined consistently with the definitions in the small employer insurer's other small group health benefit plans.

(2) A plan may exclude from coverage or limit coverage for specified conditions and services other than those required under s. Ins 8.72 but may exclude or limit only those conditions and services which are generally excluded from coverage or limited under the small employer insurer's other small group health benefit plans.

(3) A plan may apply the same limitations on provider choice, coverage and geographical service area that apply under the small employer insurer's other small group health benefit plans.

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

Ins 8.77 Copayments; coinsurance. (1) DEFINITIONS. In this section:

(a) "Primary care provider" means any of the following:

1. If the plan is an indemnity plan, a preferred provider organization or health maintenance organization that does not require the insured to designate a primary provider, the physician who normally provides care to the insured, if the physician is any of the following:

a. A physician who is not certified by any specialty board.

b. A physician certified by the American board of family practice.

c. A physician certified by the American board of internal medicine.

d. A physician certified by the American board of obstetrics and gynecology.

e. A physician certified by the American board of pediatrics.

2. If the plan is a health maintenance organization that requires an insured to designate a primary provider, the physician designated.

(b) "Specialist" means any physician other than a primary care provider.

(2) COPAYMENTS. (a) Except as provided in par. (b), sub. (4) and s. Ins 8.79, a copayment in the specified amount applies each time an insured receives any of the following:

1. Professional services from a primary care provider or from a specialist who is consulted with a referral from a primary care provider when provided during an office visit or on an outpatient basis in a hospital, ambulatory surgery center or approved treatment facility, as defined in s. 51.01 (2), Stats.: $25.

2. Professional services from a specialist when provided during an office visit or on an outpatient basis in a hospital, ambulatory surgery center or approved treatment facility, as defined in s. 51.01 (2), Stats., when the specialist is consulted without a referral from a primary care provider: $35.

3. Professional services from a chiropractor: $11.

4. Ambulance service, unless immediately admitted to the hospital: $75.

5. Treatment in a hospital emergency room, unless immediately admitted to the hospital: $75.

6. Inpatient hospitalization: $100.

7. Prescription drugs, proprietary: $20 or the cost of the prescription, whichever is less.

8. Prescription drugs, generic: $10, or the cost of the prescription, whichever is less.

(b) The copayments specified in par. (a) 1 and 2 do not apply to professional services in connection with prenatal care or well baby care from birth to 24 months.

(3) COINSURANCE. Except as provided in sub. (4) and s. Ins 8.79, for each insured individual, a plan shall pay the following portions of the amount by which covered charges in a calendar year exceed the copayments:

(a) For all charges other than for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems:

1. 80% of the first $5,000 of charges until the plan has paid $4,000.

2. 95% of the remainder of charges until the plan limit under s. Ins 8.75 (2) has been met.

(b) For the treatment of nervous or mental disorders or alcoholism or other drug abuse problems, 80% of the charges until the plan has paid $1,400 or the plan limit under s. Ins 8.75 (2) has been met.

(4) EXCEPTION FOR HEALTH MAINTENANCE ORGANIZATIONS. A plan offered by a health maintenance organization that requires participants to use only specified health care providers may elect to offer either copay-

ments or coinsurance if the amount for which a participant is responsible is the actuarial equivalent of the copayments and coinsurance required under subs. (2) and (3). Upon request, a health maintenance organization shall provide the office of the commissioner of insurance with sufficient documentation to support its determination of actuarial equivalence.

(5) DEDUCTIBLES AND OTHER COST-SHARING PROHIBITED. A plan shall not include an annual deductible or any copayment or coinsurance requirement other than those specified in this section, except as provided in s. Ins 8.79.

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

Ins 8.78 Participation; enrollment. (1) PARTICIPATION. (a) A small employer insurer shall offer a plan to any small employer meeting the definition of eligible employer in s. 635.20 (2), Stats., regardless of the number required for participation in other small group health benefit plans offered by the small employer insurer.

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

(c) A small employer insurer may impose participation requirements on a plan offered to a small employer, not to exceed the following:

1. For a group of more than 10 persons: 70% of the group.

2. For a group of 10 persons: 6 participants.

3. For a group of 8 or 9 persons: 5 participants.

4. For a group of 7 persons: 4 participants.

5. For a group of 5 or 6 persons: 3 participants.

6. For a group of 2 to 4 persons: 2 participants.

(2) PROBATIONARY PERIOD. A small employer may impose a waiting period of not more than 90 days from the date of hire before a new employe is eligible to enroll in the small employer's plan.

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

(b) An eligible employe or dependent whose coverage under another health insurance plan terminates for any reason may enroll in a small employer's plan without medical underwriting within 30 days after termination of the other coverage.

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

(b) If a plan permits employes other than those defined as eligible employes in s. 635.20 (1m), Stats., to enroll, the small employer is not required to pay the employer contribution specified under s. 635.254 (1), Stats., for those employes. If the small employer elects not to contribute, the small employer shall withhold the entire amount of the premium

from the earnings of each employe permitted to participate, as provided in s. 635.254 (2), Stats.

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

Ins 8.79 Managed care options. A small employer insurer that offers health benefit plans with one or more managed care options in the small employer market shall offer purchasers of a basic health benefit plan at least one managed care option. If the option offered is a preferred provider plan, as defined under s. 609.01 (4), Stats., the small employer insurer, in order to encourage the use of health care providers that participate in the plan, may increase any copayment specified in s. Ins 8.77 (2) or the percentage of an insured's coinsurance under s. Ins 8.77 (3) if the insured uses a nonparticipating health care provider.

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

Ins 8.80 Rating. (1) In establishing the new business premium rate for the plan, a small employer insurer shall take into account the experience of all of its small employer health benefit plans. The differences between the plan's new business premium rate and the insurer's new business premium rates for all other small employer health benefit plans shall be based solely on the differences in the plan designs and not on the actual or anticipated experience of those insured under the basic health benefit plan.

(2) (a) 1. Except as provided in par. (b), the plan shall apply a higher rate to smokers than to nonsmokers. The rate applied to smokers shall be no higher than permitted under s. 111.35 (3), Stats. The small employer insurer shall provide the small employer with enough copies of the statements required under s. 111.35 (3) (a) 2 and (b) 2, Stats., for distribution to all plan participants.

2. For the purpose of complying with s. 635.05, Stats., and s. Ins 8.52, smoking status shall be treated as a case characteristic.

(b) Paragraph (a) does not apply to a health maintenance organization federally qualified under title 13 of the public health service act.

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

Ins 8.81 Form approval and marketing. (1) Except as provided in s. 635.26 (2m) to (4), Stats., each small employer insurer shall file its basic health benefit plan policy form with the commissioner of insurance under s. 631.20, Stats., before October 1, 1993.

(2) Except as provided in s. 635.26 (2m) to (4), Stats., no small employer insurer shall market any health benefit plan to small employers on and after December 1, 1993 unless its basic health benefit plan policy form has been filed with and approved by the commissioner of insurance under s. 631.20, Stats.

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