Chapter Ins 18

HEALTH INSURANCE RISK-SHARING PLAN

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Ins 18.01 Purpose. This chapter is intended to implement and interpret subch. II of ch. 619, Stats., and s. 632.785, Stats., for the purpose of establishing procedures and requirements for a health insurance risk-sharing plan, in accordance with ss. 619.11 and 601.41 (3), Stats.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.02 Creation of plan and title. In accordance with ss. 619.11 and 601.41 (3), Stats., a plan of health insurance coverage which meets the requirements of subch. II of ch. 619, Stats., and s. 632.785, Stats., is established. The title of the plan shall be "Health Insurance Risk-Sharing Plan", and shall be referred to in this chapter as the plan.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.03 Scope. This chapter shall apply to all insurers as defined in s. 619.10 (5), Stats.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.04 Definitions. For the purpose of this chapter, the definition of terms used shall be those definitions set forth in s. 619.10, Stats.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.05 Eligibility. Eligibility shall be determined in accordance with s. 619.12, Stats.

(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.

(2) NON-ELIGIBILITY. (a) Exclusions from eligibility for the plan shall be as set forth in s. 619.12 (2), Stats.

(b) For purposes of s. 619.12 (2) (b) 1, Stats., a person is considered to have voluntarily terminated coverage under the plan if the policy terminates because of failure to pay the premium.

(2m) SPECIAL ELIGIBILITY REQUIREMENTS. Section 619.12 (2) (e) 1., Stats., does not preclude eligibility for coverage under the plan under any of the following conditions:

(a) *Limited coverage under employer plan.* 1. The health care benefits plan for which the person is eligible through his or her employer includes a rider excluding coverage for one or more of the person's conditions for more than 12 months or provides more limited coverage than the coverage available to others covered by the employer's plan.

2. The person has continued coverage under s. 632.897, Stats., or the federal consolidated omnibus budget reconciliation act of 1985, as amended.

(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.

(3) BOARD REVIEW. Any person denied coverage under the plan or whose coverage is terminated by the administering carrier is entitled to a review by the board under the grievance procedures established by the board under s. 619.15 (3) (a), Stats. Persons denied the premium or deductible reductions under s. Ins 18.12 are entitled to a review under this section.

(4) DATE OF ELIGIBILITY. Except as provided in s. 619.14 (1) (b), Stats., persons certified as eligible for the plan shall be deemed eligible for coverage from the date of application for coverage by the plan. Any individual anticipating termination under an individual plan or group health insurance policy or any other plan providing coverage similar to that under a health insurance policy, including medical assistance, may seek

to establish eligibility for the plan prior to termination of existing coverage, in order to maintain continuous coverage to the greatest extent possible.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81; am. (3), Register, August, 1986, No. 368, eff. 9-1-86; r. and recr. (1), am. (3), Register, February, 1989, No. 398, eff. 3-1-89; (2) renum. (2) (a), cr. (2) (b), Register, April, 1991, No. 424, eff. 5-1-91; cr. (2) (c), Register, June, 1992, No. 438, eff. 7-1-92; am. (1), renum. (2) (c) to be (2m) (a) and am. (intro.), cr. (2m) (b), Register, November, 1993, No. 455, eff. 12-1-93.

Ins 18.06 Participation of insurers. Every insurer shall share in the expenses of the plan as provided in s. 619.13 (1) (b), Stats. In setting premiums under s. Ins 18.07 (5), the board of governors shall not include any subsidies for the reduction of the cost of premiums or of deductibles in the calculation of operating and administrative costs of the plan. The commissioner may waive the assessment for an insurer or any class of insurers for any year when it is determined that the administrative costs of collecting the assessment would exceed the amount of the assessment.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81; am. Register, June, 1992, No. 438, eff. 7-1-92.

Ins 18.07 Coverage. Coverage shall conform with s. 619.14, Stats.

(1) LIMITATIONS ON COVERAGE OFFERED TO ELIGIBLE PERSONS ALSO ELIGIBLE FOR MEDICARE. Limitations on coverage offered shall conform with s. 619.14 (1), Stats. In accordance with s. 619.14 (2) (b), the plan shall offer an alternative to the major medical policy for individuals who are eligible for the plan and also eligible for medicare.

(2) MAJOR MEDICAL EXPENSE COVERAGE. Major medical expense coverage shall conform with s. 619.14 (2), Stats.

(3) COVERED EXPENSES. (a) Covered expenses shall be those services and articles enumerated in s. 619.14 (3), Stats. The formula for determining usual and customary charges shall be developed by the administering carrier and approved by the board.

(b) The plan shall cover services for a chronically mentally ill policyholder in a community support program under s. 619.14 (3) (c) 3, Stats., if the case management review under s. Ins 18.13 (3) (c) determines that the services are medically necessary, appropriate and cost effective.

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(4) EXCLUSIONS. Exclusions from coverage shall conform with s. 619.14 (4), Stats.

(a) The formula for determining the prevailing charge in the locality where the service is provided shall be developed by the administering carrier and approved by the board.

(b) The medical necessity of the service shall be determined by the administering carrier and shall be subject to board review under the grievance procedures established by the board under s. 619.15 (3) (a), Stats.

(5) PREMIUMS, DEDUCTIBLES AND COINSURANCE. (a) Premiums, deductibles and coinsurance shall conform with ss. 619.14 (5), 619.165 and 619.17, Stats.

(b) The schedule of annual premiums for the period from July 1, 1993, to June 30, 1994, for persons not entitled to a premium reduction under s. 619.165, Stats., is as follows:

MAJOR MEDICAL PLAN - Males

Age Group	Zone 1	Zone 2	Zone 3
0-24	$1,392	$1,252	$1,112
25-29	1,404	1,264	1,124
30-34	1,608	1,448	1,288
35-39	1,648	1,484	1,320
40-44	2,044	1,840	1,636
45-49	2,532	2,280	2,024
50-54	3,156	2,840	2,524
55-59	3,912	3,520	3,128
60-64	4,592	4,132	3,672

MAJOR MEDICAL PLAN - Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	$1,392	$1,252	$1,112
19-24	1,900	1,712	1,520
25-29	1,908	1,716	1,528
30-34	2,136	1,924	1,708
35-39	2,168	1,952	1,736
40-44	2,464	2,216	1,972
45-49	2,816	2,536	2,252
50-54	3,200	2,880	2,560
55-59	3,620	3,260	3,896
60-64	4,032	3,628	3,224

MEDICARE PLAN - Males

Age Group	Zone 1	Zone 2	Zone 3
0-24	$1,136	$1,136	$1,024
25-29	1,136	1,136	1,024
30-34	1,136	1,136	1,024
35-39	1,136	1,136	1,024
40-44	1,136	1,136	1,024
45-49	1,268	1,140	1,024
50-54	1,580	1,420	1,440
55-59	1,956	1,760	1,564
60-64	2,296	2,068	1,836

MEDICARE PLAN - Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	$1,136	$1,136	$1,024
19-24	1,136	1,136	1,024
25-29	1,136	1,136	1,024
30-34	1,136	1,136	1,024
35-39	1,136	1,136	1,024
40-44	1,232	1,136	1,024
45-49	1,408	1,268	1,128
50-54	1,600	1,440	1,280
55-59	1,812	1,632	1,448
60-64	2,016	1,816	1,612

(bg) 1. The annual rates applicable to standard risks under individual policies providing substantially the same coverage and deductibles as the plan's major medical plan for the period from July 1, 1993, to June 30, 1994, are as follows:

MAJOR MEDICAL PLAN - Males
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-24	$ 700.00	$ 630.00	$ 560.00
25-29	736.00	662.40	588.80
30-34	808.00	727.20	646.40
35-39	920.00	828.00	736.00
40-44	1,088.00	979.20	870.40
45-49	1,328.00	1,195.20	1,062.40
50-54	1,680.00	1,512.00	1,344.00
55-59	2,200.00	1,980.00	1,760.00
60-64	2,948.00	2,653.20	2,358.40

MAJOR MEDICAL PLAN - Females
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	$ 700.00	$ 630.00	$ 560.00
19-24	1,072.00	964.80	857.60
25-29	1,104.00	993.60	883.20
30-34	1,172.00	1,054.80	937.60
35-39	1,276.00	1,148.40	1,020.80
40-44	1,424.00	1,281.60	1,139.20
45-49	1,616.00	1,454.40	1,292.80
50-54	1,868.00	1,681.20	1,494.40
55-59	2,184.00	1,965.60	1,747.20
60-64	2,592.00	2,332.80	2,073.60

2. The annual rate applicable to a standard risk under an individual policy providing substantially the same coverage and deductibles as the plan's medicare plan is 50% of the rate specified in subd. 1 for the individual's age, sex and zone.

3. In calculating the annual premium for an individual eligible for a reduction in premium, the plan shall apply the appropriate percentage specified in s. 619.165 (1) (b) 1 to 4, Stats., to the rate specified for that individual in subd. 1 or 2. The annual premium calculated under this subdivision shall be rounded to the nearest whole dollar amount that is divisible by 4.

(br) For the purposes of pars. (b) and (bg), Zone 1 shall contain all of the Wisconsin postal zip code areas in which the first 3 digits are 532. Zone 2 shall contain postal zip code areas in which the first 3 digits are 530, 531, 534 and 537. Zone 3 shall contain postal zip code areas not contained in Zones 1 and 2.

(c) The commissioner shall have on file an actuarial report detailing the process by which rates were determined.

(d) The annual report of the board to the chief clerk of each house of the legislature required by s. 619.15 (2), Stats., and s. Ins 18.08 (2) shall include a section describing premium rate setting in detail. In order to fulfill this requirement, the board may appoint an actuarial committee under the powers granted to the board in s. 619.15 (5), Stats., and s. Ins 18.08 (3) (d) and (e).

(6) PRE-EXISTING CONDITIONS. Pre-existing conditions limitations shall conform with s. 619.14 (6), Stats. Determinations of what constitutes a pre-existing condition shall be made by the administering carrier and shall be subject to board review under the grievance procedures established by the board under s. 619.15 (3) (a), Stats.

(7) COORDINATION OF BENEFITS. There shall be coordination of benefits as provided in s. 619.14 (7), Stats.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.; r. and recr. (5) (b), Register, June, 1982, No. 318, eff. 7-1-82; r. and recr. (5) (b), Register, December, 1983, No. 336, eff. 1-1-84; r. and recr. (5) (b) 1., Register, December, 1984, No. 348, eff. 1-1-85; am. (5) (b) 1., Register, December, 1985, No. 360, eff. 1-1-86; r. and recr. (5) (b) 1., Register, December, 1986, No. 372, eff. 1-1-87; r. and recr. (5) (b) 1. and 2., Register, May, 1990, No. 413, eff. 6-1-90; renum. (3) to be (3) (a), cr. (3) (b), r. and recr. (5) (b) 1 (schedule), Register, June, 1991, No. 426, eff. 7-1-91; emerg. r. and recr. (5) (b) 1. (schedule), eff. 7-1-91; r. and recr. (5) (b) 1. (schedule), Register, October, 1991, No. 430, eff. 11-1-91; emerg. am. (5) (a) and (c), renum. (5) (b) 1. and 2. to be (5) (b) (intro.) and (br) and am., cr. (5) (bg), eff. 1-1-92; am. (5) (d), Register, April, 1992, No. 436, eff. 5-1-92; am. (5) (a) and (c), renum. (5) (b) 1. and 2. to be (5) (b) (intro.) and (br) and am., r. and recr. (5) (b) schedule, cr. (5) (bg), Register, June, 1992, No. 438, eff. 7-1-92; emerg. am. (5) (b) and (bg) 1., eff. 4-20-93; r. and recr. (5) (b) and (bg) 1., Register, August, 1993, No. 452, eff. 9-1-93.

Ins 18.08 Board of governors. The board shall be appointed and shall operate pursuant to s. 619.15, Stats.

(1) BOARD APPOINTMENTS. The board shall be appointed pursuant to s. 619.15 (1), Stats.

(2) ANNUAL REPORT. The board shall make an annual report to the members of the plan and to the chief clerk of each house of the legislature pursuant to s. 619.15 (2), Stats.

(3) BOARD FUNCTIONS. Board functions shall conform with ss. 619.15 (3), (4) and (5), Stats.

(a) The board shall carry out the functions required in s. 619.15 (3), Stats.

(b) The board may carry out the functions authorized in s. 619.15 (4), Stats.

(c) The board may provide for agent commissions and require agents and companies to provide assistance in filing applications under the powers granted in s. 619.15 (5), Stats.

(d) The board may establish subcommittees and appoint members who do not serve on the board to these subcommittees in order to carry out its functions under s. 619.15, Stats.

(e) The board may hire consultants in order to carry out its functions under s. 619.15, Stats.

(f) The board shall contract with the administering carrier of the plan to provide those services enumerated in s. 619.16 (3), Stats., as well as any other functions enumerated in the contract between the board and the administering carrier, in order to carry out its functions under s. 619.15, Stats.

(g) The board may defer payment of administrative expenses to the administering carrier, in accordance with the terms set forth in the contract between the board and the administering carrier.

(h) The board shall develop a detailed written policy regarding confidentiality of records.

(i) The board may adopt and amend from time to time reasonable operating procedures which are not inconsistent with the statutory requirements and ch. Ins 18, for the management and operation of the plan.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81; am. (1), Register, December, 1983, No. 336, eff. 1-1-84; am. (2), Register, April, 1992, No. 436, eff. 5-1-92.

Ins 18.09 Administering carrier. The selection, term and functions of the administering carrier shall conform with s. 619.16, Stats.

(1) SELECTION. The board shall select an insurer through a competitive bidding process to administer the plan based on criteria established by the board which shall conform with the requirements of s. 619.16 (1), Stats.

(2) TERM SERVED AND SELECTION FOR SUCCEEDING PERIODS. The term served by the administering carrier and the selection of the administering carrier for succeeding periods shall conform with s. 619.16 (2), Stats.

(3) FUNCTIONS. The administering carrier shall perform the functions enumerated in s. 619.16 (3), Stats., and any other functions agreed to in the contract between the board and the administering carrier.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.10 Notice of mandatory risk-sharing plan. Notice of the plan shall conform with s. 632.785, Stats.

(1) WHEN NOTICE REQUIRED. If an insurer takes one or more of the actions enumerated in s. 632.785 (1), Stats., the insurer shall notify all persons covered or to be covered by the policy, including parents and guardians in cases involving minor children and individuals adjudged incompetent, of the existence of the plan, as well as the eligibility requirements and the method of applying for coverage under the plan, in accordance with s. 632.785 (1), Stats.

(2) FORM OF NOTICE REQUIRED. "Wisconsin HIRSP Health Insurance Risk-Sharing Plan," an informational pamphlet prepared by the office of the commissioner of insurance and endorsed by the board, shall satisfy the notice requirements set forth in s. 632.785 (1), Stats. Any other notice given in accordance with s. 632.785 (1), Stats., shall substantially

conform to this pamphlet in type size and readability and shall be subject to the prior approval of the commissioner of insurance.

(3) STATEMENT OF REASONS FOR REJECTION, TERMINATION, CANCELLATION OR IMPOSITION OF UNDERWRITING RESTRICTIONS. The insurer's rejection, termination, cancellation or imposition of underwriting restrictions under s. 632.785 (1), Stats., shall, pursuant to s. 632.785 (2), Stats., state the specific medical reason for the insurer's action.

Note: The form referenced in sub. (2), MGAC113, may be obtained from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, WI 53707-7873.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81; am. (2) and (3), Register, April, 1992, No. 436, eff. 5-1-92.

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Ins 18.11 Confidentiality and access to records. (1) CONFIDENTIALITY. Information regarding plan applicants and plan participants shall be kept confidential by the administering carrier and the board. A detailed written policy regarding confidentiality shall be developed by the board pursuant to s. 619.15 (5), Stats., and s. Ins 18.08 (3) (h).

(2) ACCESS TO RECORDS BY PLAN APPLICANTS AND PARTICPANTS. Plan applicants and participants shall have access to all of their medical records held by the plan.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.12 Premium and deductible reductions for low-income policyholders. (1) PURPOSE. The purpose of this section is to interpret and implement ss. 619.14 (5) (a) and 619.165, Stats.

(2) ELIGIBILITY. Applicants for coverage under the plan may apply for the reductions under this section. Persons covered under the plan shall reapply annually.

(3) CALCULATION OF PREMIUM AND DEDUCTIBLE REDUCTIONS. The method of calculating premium reductions is set forth in s. Ins 18.07 (5) (bg). The schedule of deductible reductions is set forth in s. 619.14 (5) (a), Stats. The availability of premium and deductible reductions is based on the availability of funds as appropriated under s. 20.145 (7) (a) and (g), Stats.

(4) APPLICATION FOR PREMIUM AND DEDUCTIBLE REDUCTIONS. An application for premium and deductible reduction is not complete until a Supplemental Application for Premium and Deductible Reduction form or a completed Wisconsin Homestead Credit Schedule H is submitted to the administrator of the plan. An application for the premium and deductible reduction shall be accompanied by or preceded by an application to the plan.

Note: A person may obtain the supplemental application for premium and deductible reduction at no charge either at the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, Wisconsin 53707-7873, or at Mutual of Omaha Insurance Company, P.O. Box 31746, Omaha, Nebraska 68131 (1-800-228-7044). The form is numbered Form 8116HIRSP APP SUPP.

(5) APPLICATION DEADLINES, EFFECTIVE DATES OF REDUCTIONS, REESTABLISHING ELIGIBILITY. (a) New plan applicants may establish eligibility for the reductions:

1. At the time of plan application. In this case, for purposes of the premium reduction, the administering carrier shall bill the applicant the reduced premium unless the first premium payment is submitted with the application. If the first premium payment is submitted with the application, the applicant shall receive a refund of the reduced portion of the premium. Deductible reductions take effect upon issuance of the policy.

2. After eligibility for the plan is established. a. If eligibility for the premium reduction is established within 31 days after the effective date of the policy, the new policyholder shall receive a refund of the reduced portion of the premium retroactive to the effective date of the policy. If eligibility for the reduced premium is not established within 31 days after the effective date of the policy, the policyholder shall receive no refund. In this case, the policyholder shall establish eligibility at least 60 days before the renewal date on which it is to take effect, and the ad-

ministering carrier shall bill the policyholder the reduced premium beginning on the renewal date.

b. If eligibilty for the deductible reduction is established within 31 days after the effective date of the policy, the new policyholder shall receive a refund of a portion of the deductible paid by the policyholder prior to establishing eligibility. The amount of the refund shall be the difference between the deductible paid by the policyholder and the deductible as reduced by any reduction to which the policyholder is entitled. If eligibility is not established within 31 days after the effective date of the policy, the policyholder shall receive no refund. In this case, the policyholder shall establish eligibility at least 60 days before the policy's renewal date, and the deductible reduction shall take effect on January 1 of the year commencing after the policy's renewal date.

(b) Persons who are existing policyholders as of March 31 shall apply annually by May 1 in order to be eligible for the reductions for the year beginning on July 1. For premium reductions, if the application is not postmarked by May 1, then the application shall be postmarked at least 60 days prior to the policyholder's next policy renewal date in order for the corresponding premium notice to reflect the reduced premium. An existing policyholder who is first determined to be eligible for a premium reduction shall receive a refund on a pro rata basis for the time period between July 1 of each calendar year and the next renewal date. Deductible reductions under this paragraph take place on January 1 of the year following establishment of eligibility. Under this subsection, the administering carrier shall treat any individual who becomes a policyholder after March 31 as a new policyholder.

(c) Eligibility for the premium and deductible reductions shall be reestablished annually. Once eligibility is established, it is effective until the following July 1 at which time eligibility for the following year, from July 1 to June 30, shall have been established.

History: Cr. Register, August, 1986, No. 368, eff. 9-1-86; am. (1) to (5), cr. (5) (a) 2. b., Register, February, 1989, No. 398, eff. 3-1-89; emerg. am. (3), eff. 1-1-92. (5) (a) 1. and 2. (b), Register, April, 1992, No. 436, eff. 5-1-92; am. (3), Register, June, 1992, No. 438, eff. 7-1-92.

Ins 18.13 Cost containment services. (1) PURPOSE. This section implements and interprets s. 619.17 (4) (a), Stats., by establishing cost containment provisions for the Plan.

(2) DEFINITIONS. In this section:

(a) "Case management" means a review of the medical necessity and appropriateness of the treatment or procedures used in connection with specified medical conditions.

(b) "Preadmission and concurrent review of hospital admissions" means a review of the medical necessity and appropriateness of a hospital admission prior to and during a hospital stay.

(c) "Pretreatment and concurrent review of selected outpatient services" means a review of the medical necessity and appropriateness of a plan of treatment prior to and during the treatment.

(3) REQUIRED COST CONTAINMENT SERVICES. The Plan shall include the following cost containment services:

(a) Preadmission and concurrent review of hospital admissions;

(b) Pretreatment and concurrent review of selected outpatient services; and

(c) Case management.

(3m) ADDITIONAL BENEFITS. The plan may cover expenses for a benefit not specified under s. 619.14 (3), Stats., if it is determined through case management that the provision of the benefit would be more cost effective than the provision of the benefit specified under s. 619.14 (3), Stats.

(4) WRITTEN DESCRIPTION OF COST CONTAINMENT SERVICES. When a new policy is issued, a new policyholder shall receive a written description of the Plan's cost containment services and the procedures that the policyholder shall follow in order to comply with these cost containment services. Existing policyholders shall receive a written description of any change to the Plan's cost containment services or the procedures that policyholders shall follow in order to comply with these cost containment services. The existing policyholders shall receive this written description at least 30 days before the change takes effect.

History: Cr. Register, February, 1989, No. 398, eff. 3-1-89; cr. (3m), Register, June, 1991, No. 426, eff. 7-1-91.

Ins 18.14 Penalty for late assessment payment. An insurer that violates s. 619.135 (1) (b), Stats., is subject to a penalty of $250. Each week the violation continues is a separate offense.

Note: *Initial Applicability.* This section applies to penalties for late payment of assessments based on notices under s. 619.12 (am), (b) and (c), Stats., received on and after August 15, 1991.

History: Cr. Register, April, 1992, No. 436, eff. 5-1-92.