Chapter Ins 8

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

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.

Subchapter I—Employe Welfare Funds

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 compensation 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, exists where a trustee or trustees, a committee, or other party is designated jointly by one or more employers together with one or more labor organizations, solely by any employer or labor organization, or jointly by employers, or jointly by labor organizations to provide employe benefits a) under an agreement describing their responsibilities and duties, and b) from monies or other property under their control specifically segregated to provide such employe benefits.

(2) A fund, program or plan of employe benefits under which benefits are paid to participants directly out of the general funds of an employer or labor union without the actual segregation of monies or other assets to meet liabilities for benefits does not operate through means of a "trust fund or other fund". This is true although a balance sheet reserve account may be maintained for such estimated liabilities. A common plan of such type is a plan of continuation of wages in the event of sickness or accident.

(3) A fund, program or plan of employe benefits in which all benefits are provided through insurance contracts issued to an employer or labor union under which premiums are paid out of the general funds of such employer or union directly to the insurance carrier without the interposition of trustees or a fund, although employes may contribute through payroll deductions or otherwise, does not operate through means of a "trust fund or other fund".

(4) Under certain forms of insurance or annuity contracts available to pension plans, insurers guarantee that benefits will be paid to participants only to the extent that a fund or account held by them will be sufficient to provide them. Under such contracts, amounts are paid to the insurer for credit to a deposit or accumulation account. The balance in this account is held as a deposit subject to future determinations by the policyholder as to its disposition. Deposit administration contracts with variations thereof, such as immediate participation guarantees, are a common form of contract under which such unallocated funds or accounts are held. Also unallocated funds may be held to supplement or convert, at retirement, reserves under other forms of insurance or annuity contracts. This is common under forms of life or group permanent contracts. Funds, programs or plans of employe benefits which provide benefits through such unallocated funds or accounts held by insurers operate through a"trust fund or other fund". Such funds, programs or plans constitute employe welfare funds under the law irrespective of the parties and methods through which premiums are paid under sub. (3).

(5) A fund, program, or plan of employe benefits operating under a custodian or trust agreement under which a custodian receives employer contributions and purchases shares in an investment trust or other similar arrangement of pooling moneys for investment purposes constitutes an employe welfare fund if:

(a) The custodian holds such shares for the fund, program, or plan pending receipt of distribution instructions to be received when a participant in the plan qualifies for a benefit distribution, and

(b) The employer contributing to the plan determines when an employe is to be enrolled under the plan and qualifies for a benefit distribution.

(6) Where a trust or fund receives contributions from more than one employer and these contributions are commingled for investment purposes, a separate employe welfare fund exists for each employer segment of the trust if separate computations or allocations are made to each employer segment of the trust for the benefit cost, insurance experience, or gains from forfeited benefits arising from participants.

(7) Where a trust or fund is established by one employer to hold moneys for 2 or more employe benefit plans for different groups of employes of that employer, one fund exists if all the assets of the trust or fund are available for benefit payments under any of the plans. Where separate accounting is required to be maintained by the trustee, so that only a designated portion of the total trust is available for benefit payments under each plan, an employe welfare fund exists for each plan portion of the trust or fund.

History: Cr. Register, July, 1962, No. 79, eff 8−1−62; cr. (4), (5), (6), Register, October, 1968, No. 154, eff. 11−1−68; am. title, (1) (a), (b), (c) and (d); r. (2) intro. and (a); renum. (2) (b) to be (2), (2) (c) to be (3); r. (2) (d); renum. (3) to be (4) and am.; renum. (4), (5), and (6) to be (5), (6) and (7), Register, December, 1970, No. 180, eff. 1−1−71; am. (1), Register, November, 1978, No. 275, eff. 12−1−78; correction made under s. 13.93 (2m) (b) 5., Stats., Register, April, 1992, No. 436.

Ins 8.03 "Employe benefits", definition. (1) The term "employe benefits" under s. 641.07 (2), Stats., must be broadly construed. The definition covers both benefits and services. Section 641.07(2), Stats., declares that the type of benefits covered by the law are not limited to those specifically enumerated therein.

(2) Section 641.07(2), Stats., enumerates 4 classes of benefits as being among the forms of benefits covered by the law. These are:

(a) Medical, surgical or hospital care or benefits.

(b) Benefits in the event of sickness, accident, disability or death.

(c) Benefits in the event of unemployment.

(d) Retirement benefits.

(3) Other types of benefits commonly offered to employes which are covered by the law include:

(a) Deferred benefits from profit−sharing savings or stock bonus plans.

(b) Benefits upon termination of employment.

(c) Vacation benefits.

History: Cr. Register, July, 1962, No. 79, eff. 8−1−62; am. (1) and (2), Register, November, 1978, No. 275, eff. 12−1−78.

Ins 8.04 Registration requirements. (1) Every employe welfare fund within the meaning of s. 641.07 (1), Stats., must be registered with the commissioner of insurance within 3

months after the first day on which coverage is provided for any person employed in Wisconsin. For purposes of computing the time in which to register a fund in which the plan is back−dated or provides coverage to participants retroactively, the plan should be construed to provide coverage as of the date of its formal establishment.

(2) Registration shall be made on form No. 71−3. A fund which covers more than 25 persons employed in Wisconsin at the time of registration must file a copy of the following documents, if applicable, as a part of such registration:

(a) Plan, as amended to date

(b) Trust indenture, as amended to date

(c) Any separate contract or other instrument under which the fund is administered

(d) Collective bargaining agreement(s), or provisions thereof relating to the fund, as currently in force

(e) Any booklet or other written material descriptive of the fund which is given or made available to employes

(3) An employe welfare fund which does not cover more than 25 persons employed in Wisconsin at the time of registration is not required to submit copies of fund documents when registered; however, if subsequently it provides coverage to more than 25 persons employed in Wisconsin, the fund documents must be submitted with the annual statement for the first year in which more than 25 persons employed in Wisconsin are covered.

History: Cr. Register, July, 1962, No. 79, eff. 8−1−62; am. (1), Register, November, 1978, No. 275, eff. 12−1−78.

Ins 8.05 Registration cancellation. When a registered employe welfare fund is merged or consolidated with another fund, or is terminated, or ceases to cover any person employed in Wisconsin, the trustee of such fund must file written notice of such action with the commissioner of insurance within 30 days after its occurrence. Such notice shall be verified by the oath of the trustee of the fund, or if there is more than one trustee, then by the oaths of at least 2 trustees. If more than 25 persons employed in Wisconsin were covered by such fund, the notice shall include a certified true copy of the resolution of the trustees or of the board of directors of the employer or similar authority under which such action was taken.

History: Cr. Register, July, 1962, No. 79, eff. 8−1−62.

Ins 8.06 Annual statement and notice of number of fund participants in Wisconsin, when required. (1) An annual statement on form No. 71−9 must be filed under s. 641.13, Stats., by the trustee of every employe welfare fund subject to ch. 641, Stats., for each fiscal year of the fund during which coverage is provided to more than 25 persons employed in Wisconsin. The annual statement must be filed within 5 months after the close of the fiscal year of the fund.

(2) The trustee of every employe welfare fund subject to ch. 641, Stats., within 5 months after the close of its first fiscal year during which less than 26 persons employed in Wisconsin were covered, must file a written notice with the commissioner of insurance that less than 26 persons employed in Wisconsin participated in the fund during such year. Such notice will remain in effect for all subsequent years until the first year thereafter during which more than 25 persons employed in Wisconsin participate at any time. The filing of a notice under this rule does not relieve the trustee of a fund from the responsibility to file an annual statement for any year during which more than 25 persons employed in Wisconsin participate in the fund. If an annual statement must be filed for any year after a notice has been filed, the procedure of filing a notice will again apply for the first year thereafter during which coverage is provided to less than 26 persons employed in Wisconsin. Such renewed notices shall have the same force and effect as an initial notice.

(3) When an employe welfare plan which covers more than 25 persons employed in Wisconsin is terminated and fund assets are completely distributed or paid over to another fund, an annual statement must be filed under s. 641.13, Stats., within 5 months after the date of final distribution of the fund. Such annual statement must report the affairs of the fund from the date of the last previous annual statement and must reflect the final accounting of the fund for the transfer or distribution of all its assets.

(4) When an employe welfare plan is terminated but assets are held for distribution at a later date, the fund remains subject to ch. 641, Stats., as long as at least one Wisconsin employe participates. Annual statements must be filed by the trustee of any such fund for every year in which more than 25 persons employed in Wisconsin participate at any time. Notice under sub. (2) must be given for the first fiscal year in which less than 26 persons employed in Wisconsin participate. Notice of termination of the fund must be given in accordance with s. Ins 8.05.

History: Cr. Register, July, 1962, No. 79, eff. 8−1−62; am. Register, November, 1978, No. 275, eff. 12−1−78.

Ins 8.07 "Persons employed in this state". The term "persons employed in this state" as used in ch. 641, Stats., includes both active employes in Wisconsin and retired or terminated persons participating in the fund who were employed in Wisconsin at the time of retirement or other separation. The term includes anyone whether or not a resident of Wisconsin, who is employed at a place of business maintained by an employer in the state of Wisconsin; however, an employe who is not regularly employed at a place of business maintained by an employer shall be deemed to be employed in Wisconsin if service is performed solely within Wisconsin, or if service is performed partly within Wisconsin and partly outside of Wisconsin and

(1) The service outside of Wisconsin is incidental to service within Wisconsin (for example, is occasional, temporary or transitory in nature) or

(2) The base of operations is in Wisconsin, or

(3) If there is no base of operations, then the place from which the service is directed or controlled is in Wisconsin.

Note: Example: A seller who spends 20% of the hours of employment in Wisconsin and who works from a base of operations in Wisconsin would be "employed in this state". A seller who spends 50% of the hours of employment in Wisconsin but who works from a base of operations outside of Wisconsin would not be "employed in this state". A seller whose service is performed primarily in Wisconsin (service outside of the state is only occasional) is"employed in this state" even though the base of operations is in another state or is directed or controlled from another state.

History: Cr. Register, July, 1962, No. 79, eff. 8−1−62; am. (intro.), Register, November, 1978, No. 275, eff. 12−1−78; correction made under s. 13.93 (2m) (b) 5., Stats., Register, April, 1992, No. 436.

Ins 8.08 Availability of information to fund participants. The following information shall be available to all fund participants, including covered employes and their beneficiaries, contributing employers and participating labor organizations, in the office of the fund at all reasonable hours: (In the case of a fund which is administered solely by an employer or union, a separate fund office may not be maintained. In such case the following information must be available at the principal office of the employer or union in this state.)

(1) Copy of registration statement under s. 641.08, Stats., including all current fund documents specified by such statement. A fund which covers less than 26 persons employed in Wisconsin must maintain such documents although it is not required to file them with the commissioner of insurance under s. Ins 8.04.

(2) Copies of annual statements under s. 641.13, Stats., for the 3 latest fiscal years.

(3) Copy of latest report of examination of the fund by the commissioner of insurance.

History: Cr. Register, July, 1962, No. 79, eff. 8−1−62; am. (1) and (2), Register, November, 1978, No. 275, eff. 12−1−78.

Ins 8.09 Preservation of records. The trustee of every employe welfare fund subject to ch. 641, Stats., shall maintain the books and records of such fund in sufficient detail to permit a thorough examination of the operations of such fund by the commissioner of insurance for a period of 5 years after the close of the fiscal year of such fund in which the entries in such books or records are made. Such books and records shall include all journals, ledgers, checks, vouchers, invoices, receipts, bank statements, minutes, resolutions, agreements, contracts and other records of original or final entry. The preservation of photographic reproductions of such records shall constitute compliance with the requirements of this rule.

History: Cr. Register, July, 1962, No. 79, eff. 8–1–62; am. Register, November, 1978, No. 275, eff. 12–1–78.

Ins 8.10 Advisory council on employe welfare plans. (1) PURPOSE. The purpose of this rule is to create an advisory council on employe welfare plans to be appointed by the commissioner of insurance pursuant to ss. 15.04 (3) and 601.20, Stats.

(2) MEMBERSHIP. This council shall consist of the commissioner or a member of his or her staff designated by the commissioner and 8 other members having competence in the field of employe welfare funds, 2 to be representatives of management, 2 to be representatives of employes, and 4 to be representatives of the general public.

(3) TERM. Members of the council shall be appointed to serve for a term of 2 years except that the initial appointments under this rule shall be 4 members for a one–year term and 4 members for a 2–year term.

(4) DUTIES. It shall be the duty of the council to:

(a) Advise the commissioner with respect to the carrying out of functions under ch. 641, Stats.,

(b) Review the administration of ch. 641, Stats., and

(c) Make such reports and recommendations to the commissioner with respect thereto as it deems necessary in the public interest.

(5) CHAIRPERSON. The commissioner or designee shall serve as chairperson.

(6) MEETINGS. The council shall meet at least twice each year when called by the commissioner and at such other times when requested by the commissioner or 2 or more members.

(7) EXPENSE REIMBURSEMENT. Members of the council shall receive no salary or compensation for service on the council but shall be reimbursed for their actual and necessary expenses in attending meetings or while performing other duties as directed by the commissioner.

History: Cr. Register, July, 1970, No. 175, eff. 8–1–70; am. (4)(a) and (b), 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 8.11 County and school district self–insured employe health care benefits: excess or stop–loss insurance requirements. (1) PURPOSE. This section interprets ss. 59.07 (2) (c) and 120.13 (2) (c), Stats., for the purpose of prescribing detailed requirements for excess or stop–loss insurance for self–insured employe health care benefit plans provided by counties or school districts.

(2) SCOPE. This section applies to any county or school district that alone or together with one or more counties or one or more school districts provides employe health care benefits on a self–insured basis to less than 1,000 covered employes.

(3) DEFINITIONS. In this section:

(a) "Aggregate claims" means total actual claim amounts incurred under the employe health care benefit plan during a benefit period.

(b) "Aggregate deductible" means the aggregate amount of liability specified in the excess or stop–loss insurance contract at or below which the county or school district remains liable for payments for eligible claims.

(c) "Benefit period" means a twelve–month accounting or reporting period of the employe health care benefit plan.

(d) "Coinsurance" means a fixed percentage of each claim established in the employe health care benefit plan which the county or school district is obligated to pay for each person covered in the plan.

(e) "Covered employes" means employes participating in an employe health care benefit plan.

(f) "Employes eligible to participate" means employes who are eligible to be covered employes under the terms of the employe health care benefit plan.

(g) "Employe health care benefit plan" means a self–insured plan established by one county or school district or jointly by 2 or more counties or 2 or more school districts to provide health care benefits to employes eligible to participate in the plan.

(h) "Expected claims" means the most accurate actuarial estimate of aggregate claims during a benefit period.

(i) "Incurred" means to have provided or furnished a service or item to an employe or dependent covered under an employe health care benefit plan for which a charge for a covered expense is made.

(j) "Maximums" means the largest total amount of claims per person established by the employe health care benefit plan which the county or school district is obligated to pay.

(k) "Paid basis" means the application of a claim payment to the aggregate deductible for the benefit period in which the payment is actually made, regardless of when the claim is incurred.

(L) "Quota share reinsurance" means insurance purchased for the employe health care benefit plan which pays the plan a predetermined fixed percentage of each claim.

(4) EXCESS OR STOP–LOSS INSURANCE REQUIREMENTS. (a) Excess or stop–loss insurance required by s. 120.13 (2) (c), Stats., shall provide coverage for all claims incurred during the term of the policy or contract at a level at which an actuary has certified that the probability that aggregate claims will exceed 125% of expected claims is less than 5%.

(b) Each employe health care benefit plan shall be covered by one excess or stop–loss insurance policy that satisfies par. (a), regardless of the number of counties or school districts participating in the plan.

(c) Notwithstanding par. (a), a county or school district that self–insures employe health benefits under a plan in which an actuary has certified that the probability that aggregate claims will exceed 125% of expected claims is less than N% need not purchase excess or stop–loss insurance.

(5) EXCESS OR STOP–LOSS INSURANCE PROVIDED ON A PAID BASIS. (a) Excess or stop–loss insurance required by s. 120.13 (2) (c), Stats., may provide coverage on a paid basis.

(b) Upon termination for any reason of an excess or stop–loss insurance policy that provides coverage on a paid basis, the policy shall apply all claims incurred but not paid prior to the termination of the policy to the aggregate deductible of the benefit period in which the service or item was provided or furnished to an employe or dependent under the self–insured employe health care benefit plan.

(6) ACTUARIAL CERTIFICATION. (a) Every county or school district with a plan that is subject to s. 120.13 (2) (c), Stats., shall file with the commissioner of insurance within 30 days after the effective date of the self–insured employe health care benefit plan, every 3 years thereafter and whenever a material change occurs to the plan, an actuarial certification that includes information on:

1. The number of employes eligible to participate in the plan and the number of covered employes in the plan.

2. A description of the plan's coverage including but not limited to an outline of benefits provided, deductibles, coinsurance, maximums and quota share reinsurance, if any.

3. A statement that the plan satisfies the excess or stop–loss insurance requirements specified in sub. (4).

4. Except for a county or school district with a plan subject to s. 641.08, Stats., a copy of the excess or stop–loss insurance contract and of the plan for self–insuring.

Note: A county or school district with a plan subject to ch. 641, Stats., must already file this information with the commissioner.

(b) The actuarial certification required in par. (a) may be filed by an actuary employed by the excess or stop–loss insurer or by an actuary independent of the excess or stop–loss insurer.

(c) Two or more counties or 2 or more school districts that jointly establish an employe health care benefit plan shall designate the individual who will file the actuarial certification required in par. (a). Only one actuarial certification shall be filed for the plan.

Note: The commissioner of insurance will utilize the following tables to evaluate actuarial certifications for accuracy and compliance with this section. The following example illustrates the application of the tables. This example only gives a basic description of how to use the following tables. It may be necessary to extrapolate or interpolate from the information given in the tables in order to apply the tables to a particular plan. An actuary or other qualified person should be consulted to be certain that a plan meets the requirements of sub. (4). Also note that no table provides a description of dental or vision plan benefits. Under sub. (4) (c), many dental or vision plans may not need to purchase stop–loss insurance.

Example

Assume a school district has a self–insured employe health care benefit plan that covers 250 employes and family members. The plan offers individual specific stop–loss of $25,000 and provides benefits with a $500.00 deductible per person, 80% coinsurance and $1,000.00 out–of–pocket limit per person.

The plan's stop–loss coverage and benefit package are the same as that used in Table 7. Therefore, use Table 7 for determining whether the plan meets the requirements in sub. (4).

In Table 7, use the 125 percent of mean line. Since sub. (4) (a) deals with "125% of expected claims," refer to the 125% of mean line when using any of the tables.

To determine whether the probability that aggregate claims will exceed 125% of expected claims is less than 5%, subtract the decimal numbers shown in the tables from the number "1". For example, for a plan offering the benefits described in Table 7 and having 25 employes, the probability that aggregate claims will exceed 125% of expected claims is 28% (1 minus .72= .28). It is 26% for 50 employes (1 minus .74), 23% for 100 employes (1 minus .77), etc.

In this example, the plan covers 250 employes. Table 7 shows that at 250 employes, the probability that aggregate claims will exceed 125% of expected claims is 18% (1 minus .82).

In order to comply with the rule, this probability must be less than 5%. In this example, the probability is 18%. Therefore, the school district or county must purchase aggregate stop–loss insurance at a level sufficient to bring this probability down to less than 5%. Stop–loss insurance is sold at various levels, including a level at which the probability that aggregate claims will exceed 125% of expected claims is less than 5%. At a minimum, the school district or county should purchase stop–loss insurance at this level.

Table 8.11–1

STATE OF WISCONSIN

Distribution of Medical Claim Individual Specific Stop Loss Level: $5,000 July 1, 1987 Probability that Medical Claims are Less Than a Given Percent of Mean $0 Deductible, 100 Percent Coverage

Percent of Mean	Employes				
	100	250	500	1,000	5,000
50%	.04	.01	.00	.00	.00
75	.19	.14	.06	.01	.00
100	.53	.52	.51	.51	.51
105	.60	.61	.63	.70	.86
110	.67	.69	.74	.84	.96
115	.73	.77	.83	.92	.99
120	.78	.83	.89	.97	1.00
125	.83	.87	.94	.99	1.00
130	.86	.90	.96	1.00	1.00
150	.95	.98	1.00	1.00	1.00

Table 8.11–2

STATE OF WISCONSIN

Distribution of Medical Claim Individual Specific Stop Loss Level: $10,000 July 1, 1987 Probability that Medical Claims are Less Than a Given Percent of Mean $0 Deductible, 100 Percent Coverage

Percent of Mean	Employes				
	100	250	500	1,000	5,000
50%	.05	.01	.00	.00	.00
75	.21	.14	.06	.01	.00
100	.53	.52	.52	.51	.51
105	.60	.61	.63	.69	.85
110	.66	.69	.74	.83	.96
115	.72	.76	.83	.91	.99
120	.77	.82	.89	.96	1.00
125	.82	.86	.93	.99	1.00
130	.85	.90	.96	1.00	1.00
150	.94	.98	1.00	1.00	1.00

Table 8.11–3

STATE OF WISCONSIN

Distribution of Medical Claim Individual Specific Stop Loss Level: $25,000 July 1, 1987 Probability that Medical Claims are Less Than a Given Percent of Mean $0 Deductible, 100 Percent Coverage

Percent of Mean	Employes				
	100	250	500	1,000	5,000
50%	.06	.01	.00	.00	.00
75	.24	.15	.07	.01	.00
100	.54	.53	.53	.52	.52
105	.60	.61	.63	.68	.83
110	.66	.70	.73	.82	.95
115	.71	.75	.81	.90	.99
120	.76	.80	.87	.95	1.00
125	.80	.85	.92	.98	1.00
130	.83	.89	.95	.99	1.00
150	.92	.97	1.00	1.00	1.00

Table 8.11–4

STATE OF WISCONSIN

Distribution of Medical Claim Individual Specific Stop Loss Level: Unlimited July 1, 1987 Probability that Medical Claims are Less Than a Given Percent of Mean $0 Deductible, 100 Percent Coverage

Percent of Mean	Employes				
	100	250	500	1,000	5,000
50%	.07	.02	.00	.00	.00
75	.29	.19	.10	.02	.00
100	.59	.56	.56	.55	.53
105	.63	.63	.64	.68	.80
110	.69	.70	.73	.79	.93
115	.73	.75	.80	.87	.98
120	.76	.79	.85	.92	1.00
125	.80	.84	.89	.95	1.00
130	.83	.87	.92	.97	1.00
150	.91	.95	.98	1.00	1.00

Table 8.11–5
STATE OF WISCONSIN
Distribution of Medical Claim Individual Specific Stop Loss Level: $5,000 July 1, 1987 Probability that Medical Claims are Less Than a Given Percent of Mean $500 Deductible Per Person, 80% Percent Coinsurance $1,000 Out–of–Pocket Limit Per Person

Percent of Mean	Employes					
	25	50	100	150	250	500
50%	.22	.13	.06	.05	.01	.00
75	.39	.32	.23	.21	.16	.07
100	.57	.55	.53	.52	.52	.52
105	.60	.60	.60	.60	.61	.63
110	.63	.64	.66	.66	.69	.73
115	.66	.68	.71	.72	.76	.81
120	.69	.72	.76	.77	.81	.88
125	.72	.74	.80	.82	.85	.92
130	.74	.77	.83	.84	.89	.95
150	.82	.87	.92	.94	.97	1.00

Table 8.11–6
STATE OF WISCONSIN
Distribution of Medical Claim Individual Specific Stop Loss Level: $10,000 July 1, 1987 Probability that Medical Claims are Less Than a Given Percent of Mean $500 Deductible Per Person, 80% Percent Coinsurance $1,000 Out–of–Pocket Limit Per Person

Percent of Mean	Employes					
	25	50	100	150	250	500
50%	.25	.16	.07	.05	.02	.00
75	.42	.34	.25	.23	.17	.08
100	.58	.55	.55	.53	.53	.53
105	.60	.60	.60	.60	.61	.63
110	.64	.64	.65	.66	.68	.73
115	.67	.67	.70	.72	.74	.80
120	.70	.71	.75	.76	.79	.86
125	.71	.74	.78	.80	.84	.91
130	.74	.77	.82	.84	.89	.94
150	.81	.85	.91	.93	.96	.99

Table 8.11–7
STATE OF WISCONSIN
Distribution of Medical Claim Individual Specific Stop Loss Level: $25,000 July 1, 1987 Probability that Medical Claims are Less Than a Given Percent of Mean $500 Deductible Per Person, 80% Percent Coinsurance $1,000 Out–of–Pocket Limit Per Person

Percent of Mean	Employes					
	25	50	100	150	250	500
50%	.29	.19	.08	.06	.02	.00
75	.47	.39	.30	.26	.19	.10
100	.61	.58	.56	.55	.54	.53
105	.64	.61	.61	.61	.61	.63
110	.66	.64	.65	.66	.67	.71
115	.68	.68	.70	.70	.73	.78
120	.70	.70	.73	.74	.79	.85
125	.72	.74	.77	.79	.82	.89
130	.74	.76	.80	.82	.86	.93
150	.80	.83	.89	.92	.95	.99

Table 8.11–8
STATE OF WISCONSIN
Distribution of Medical Claim Individual Specific Stop Loss Level: Unlimited July 1, 1987 Probability that Medical Claims are Less Than a Given Percent of Mean $500 Deductible Per Person, 80% Percent Coinsurance $1,000 Out–of–Pocket Limit Per Person

Percent of Mean	Employes					
	25	50	100	150	250	500
50%	.35	.24	.12	.09	.04	.00
75	.53	.53	.37	.32	.25	.15
100	.67	.66	.61	.59	.58	.57
105	.69	.68	.65	.64	.64	.64
110	.71	.71	.68	.68	.69	.72
115	.72	.72	.72	.72	.73	.78
120	.74	.75	.75	.75	.77	.83
125	.76	.76	.78	.79	.81	.87
130	.77	.78	.80	.81	.84	.90
150	.82	.84	.88	.89	.92	.96

(7) ACTUARY QUALIFICATIONS. The actuarial certification specified in sub. (6) shall be signed by an actuary who satisfies the requirements of s. Ins 6.12.

History: Cr. Register, April, 1988, No. 388, eff. 5–1–88.

Subchapter II—Employe Benefit Plan Administrators

Ins 8.20 Purpose. This subchapter interprets and implements ch. 633, Stats.

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

Ins 8.22 Definitions. In this subchapter:

(1) "Administrator" has the meaning given in s. 633.01 (1), Stats.

(2) "Commissioner" means the commissioner of insurance.

(3) "Employe" has the meaning given in s. 633.01 (2), Stats.

(4) "Office" means the office of the commissioner.

(5) "Plan" has the meaning given in s. 633.01 (4), Stats.

(6) "Principal" has the meaning given in s. 633.01 (5), Stats.

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

Ins 8.24 Exemptions. (1) Each of the following is exempt from ch. 633, Stats., and this subchapter for the portion of its business subject to regulation under the specified sections:

(a) An administrator of one or more self–insured, partially insured or divided insurance worker's compensation plans subject to s. DWD 80.60 or 80.61.

(b) A warrantor or warranty plan administrator, as defined in s. Ins 15.01 (4) (c) or (e), that holds a valid certificate of authority under ch. Ins 15.

(2) An administrator that is partially exempt under sub. (1) (a) or (b) is subject to ch. 633, Stats., and this subchapter for any portion of its business that is outside the scope of the exemption.

History: Cr. Register, April, 1992, No. 436, eff. 5–1–92; **correction in (1) (a) made under s. 13.93 (2m) (b) 7., Stats., Register, June, 1997, No. 498.**

Ins 8.26 Licensing. (1) APPLICATION. A person applying for a new or renewal license as an administrator shall submit an application to the office in the form prescribed by the office. With the application, the person shall submit all of the following:

(a) With the initial application, a performance bond meeting the requirements of s. Ins 8.28.

(b) With a renewal application, proof that the bond continues to meet the requirements of s. Ins 8.28, if the amount required for the bond has changed.

(c) A financial statement for the administrator's most recently completed fiscal year, prepared according to generally accepted accounting principles. The financial statement shall report the administrator's assets, liabilities and net worth, the results of operations and the changes in net worth for the fiscal year on the accrual basis.

(d) A statement as to whether the administrator does any of the following:

1. Collects premiums or employe contributions on behalf of any principal.

2. Maintains separate fiduciary accounts for each principal.

(e) All of the following information about the administrator, if an individual, or about each officer, director, partner or other individual having comparable responsibilities in the organization, if a corporation or partnership:

1. Whether the individual has been fined or reprimanded or has been the subject of a consent decree in any state by any agency that regulates the business of administrators, insurance, real estate, securities or financial institutions.

2. Whether the individual has had a license to solicit insurance, real estate or securities or to act as an administrator refused, suspended, denied or revoked in any state.

3. Whether the individual has been convicted of a felony or misdemeanor, other than a misdemeanor related to the use of a motor vehicle or the violation of a fish and game regulation.

4. If the individual has ever been employed by an administrator or insurance company, or in the business of real estate, securities or financial institutions, whether his or her employment has been terminated or nonrenewed because of allegations of misconduct or wrongdoing.

(f) If the administrator is an individual, his or her insurance intermediary agent's license number and social security number and a statement that he or she intends to act as an administrator in good faith and in compliance with all applicable laws of this state and rules and orders of the commissioner.

(g) If the administrator is a corporation or partnership, its federal identification number, the state and year of its incorporation or year of its formation and a statement that it intends to act as an administrator in good faith and in compliance with all applicable laws of this state and rules and orders of the commissioner and that it has designated or will designate an individual with direct responsibility for each plan it administers.

(h) If the administrator is an individual who is not a resident of this state or a corporation or partnership that is not organized under the laws of this state, a statement that the administrator agrees to be subject to the jurisdiction of the commissioner and the courts of this state with respect to all matters pertaining to activities as an administrator and to accept service of process as provided under ss. 601.72 and 601.73, Stats.

(i) Any other information requested by the office.

(j) The fee specified under s. 601.31 (1) (w), Stats., which shall be nonrefundable.

(2) RENEWAL APPLICATION DEADLINE. An administrator shall submit a renewal application on or before August 1 of each year.

(3) APPLICATION REVIEW. The office shall review and approve or disapprove each complete application within 60 days after its receipt.

Note: The application form, which includes a sample performance bond format, OCI 30–001, may be obtained from the Office of the Commissioner of Insurance, P.O. Box 7872, Madison, Wisconsin 53707–7872.

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

Ins 8.28 Performance bond requirements. (1) A performance bond required under s. 633.14 (1) (b) or (2) (b), Stats., shall be continuous in form, shall be issued by an insurer authorized to do a surety business in this state and shall be in favor of the commissioner and payable to any resident of this state who is the beneficiary of an employe benefit plan administered by the administrator and to any such employe benefit plan on behalf of the residents of this state who are its beneficiaries in the event of injury caused by a failure of the administrator to fulfill its responsibilities as an administrator.

(2) If the administrator collects premiums or employe contributions on behalf of any principal, or commingles funds belonging to more than one principal, the performance bond shall be in the greater of the following amounts:

(a) $25,000.

(b) Ten percent of the total amount of projected premiums, charges and claim funds the administrator expects to handle on behalf of residents of this state during the fiscal year following the year for which a financial statement is submitted under s. Ins 8.26 (1) (c). A bond under this paragraph need not exceed $500,000.

(3) If the administrator does not collect premiums or employe contributions on behalf of any principal, and maintains a separate fiduciary account for each principal, the performance bond shall be in the greater of the following amounts:

(a) $15,000.

(b) Five percent of the total amount of projected claim funds the administrator expects to handle on behalf of residents of this state during the fiscal year following the year for which a financial

statement is submitted under s. Ins 8.26 (1) (c). A bond under this paragraph need not exceed $250,000.

(4) An administrator may exclude from the calculations required under sub. (2) (b) or (3) (b) all amounts handled as administrator for any of the following:

(a) Self−insured, partially insured or divided insurance worker's compensation plans subject to s. DWD 80.60 or 80.61.

(b) Warranty plans subject to ch. Ins 15.

History: Cr. Register, April, 1992, No. 436, eff. 5−1−92; **correction in (4) (a) made under s. 13.93 (2m) (b) 7., Stats., Register, June, 1997, No. 498.**

Ins 8.30 Notification to office. An administrator shall notify the office in writing of any of the following within 30 days after the date of the occurrence:

(1) The cessation of business activities as an administrator. A notification under this subsection shall include the name and address of the custodian of the administrator's business records and the location of those records.

(2) Any change in the administrator's business mailing address or the location of its business records.

(3) Formal administrative action in this state or another state by an agency that regulates the business of administrators, insurance, real estate, securities or financial institutions against the administrator or any officer, director, partner or other individual having comparable responsibilities in the corporation or partnership.

(4) The conviction in this state or another state of a felony or misdemeanor, other than a misdemeanor related to the use of a motor vehicle or the violation of a fish and game regulation, of the administrator or any of the officers, directors, partners or other persons having comparable responsibilities in the corporation or partnership.

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

Ins 8.32 Audit. In order to determine whether the financial resources of an administrator are adequate to safeguard the interests of the public and persons covered by a plan, or to determine the appropriate bond amount under s. Ins 8.28, the office may order the administrator to submit financial statements that have been audited by a certified public accountant.

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

Subchapter III—Small Employer Health Insurance

Ins 8.40 Purpose. This subchapter interprets and implements ch. 635, Stats., and s. 619.12 (2) (e), Stats.

History: Cr. Register, October, 1992, No. 442, eff. 11−1−92; am. Register, November, 1993, No. 455, eff. 2−1−94.

Ins 8.42 Definitions. In addition to the definitions in s. 635.02, Stats., which apply to this subchapter, in this subchapter:

(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.

(2) "Commissioner" means the commissioner of insurance.

(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 February 1, 1994, 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 February 1, 1994, loses coverage under the qualifying coverage; and

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

(8) "Office" means the office of the commissioner.

(9) "Policy" means any of the following:

(a) A group health benefit plan issued to a small employer.

(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 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, and the individual health benefit plan is in fact, or in substance, sold to, or through 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) For a health benefit plan that provides coverage through a trust or association, 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.

(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 February 1, 1994.

History: Cr. Register, October, 1992, No. 442, eff. 11–1–92; renum. (1) to (3) to be (2), (8) and (9) and am. (9) (b) and (c), cr. (1), (3) to (7), (9) (d), (10) to (13), Register, November, 1993, No. 455, eff. 2–1–94.

Ins 8.44 Applicability; exclusion. (1) Subchapter I of ch. 635, Stats., and this subchapter apply to a policy issued to, or renewal 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 employer was actively engaged in the business enterprise during the 12 months preceding the date of application or the policy renewal date.

(2) A small employer insurer shall notify each employer in writing when a policy is issued that if the employer employs 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.

(3) In addition to the types of policies excluded under s. 635.02 (3m), Stats., subch. I of ch. 635, Stats., and this subchapter do not apply to policies providing only specified disease coverage or to hospital indemnity policies, as defined in s. 632.895 (1) (c), Stats.

History: Cr. Register, October, 1992, No. 442, eff. 11–1–92; am. (1), renum. (2) to be (3), cr. (2), Register, November, 1993, No. 455, eff. 2–1–94.

Ins 8.46 Required policy provisions. Each policy shall include all of the following:

(1) On the face page or first page, a statement that the policy is guaranteed renewable except for the reasons stated in the policy, which shall be consistent with s. 635.07 (1) and (2), Stats.

(2) A statement of the minimum number of eligible employes required in order to keep the policy in effect, expressed either as 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 in the policy or employer agreement. For purposes 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:

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

(b) For a small employer with 10 eligible employes, 6 eligible employes.

(c) For a small employer with 8 or 9 eligible employes, 5 eligible employes.

(d) For a small employer with 7 eligible employes, 4 eligible employes.

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

(f) For a small employer with 2 to 4 eligible employes, 2 eligible employes.

History: Cr. Register, October, 1992, No. 442, eff. 11–1–92; am. (2), Register, November, 1993, No. 455, eff. 2–1–94.

Ins 8.48 Solicitation; disclosure requirements. (1) AGENTS. Before completing an application for a policy, an agent shall provide the small employer or representative of the small employer or the individual applicant with a form stating the information required under s. 635.11 (1) to (4), Stats. The agent shall sign and date the form certifying that he or she made the required disclosure and shall obtain the signature of the small employer or representative of the small employer or the individual applicant on the form. The agent shall give one copy of the completed form to the person who signed it. The agent or small employer insurer shall retain one copy of the completed form.

(2) SMALL EMPLOYER INSURERS. A small employer insurer that does not use agents to solicit or sell policies shall, with any solicitation material, provide the small employer or individual applicant with a form stating the information required under s. 635.11 (1) to (4), Stats. The small employer insurer shall secure with or as part of each application a form signed by the small employer, a representative of the small employer or individual applicant stating that he or she has received the information. The small employer insurer shall provide a copy to the person who signed the form no later than the date the policy is issued.

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

Ins 8.50 Underwriting restriction. In determining whether to issue or continue to provide coverage to a small employer, a small employer insurer may not consider the occupation of the employes of the small employer or the type of business in which the small employer is engaged.

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

Ins 8.52 Regulation of rates and rate changes. (1) IDENTIFICATION OF THE SET OF MIDPOINT RATES. (a) Each small employer insurer shall identify a set of rates applicable to all combinations of case characteristics and benefit design characteristics that serves as the set of midpoint rates for policies issued to small employers. These rates shall be represented by any combination of rates and rating factors that satisfy the following:

1. All differences among rates in the set shall be in accordance with the insurer's rate manual or rating procedures and shall be based on the actuarially determined values of the differences in case characteristics and benefit design characteristics.

2. The differences among the rates may not reflect any differences due to such factors as the claim experience, health status and duration of coverage of an individual policy or a collection of policies grouped according to anything other than case characteristics or benefit design.

(b) The set of midpoint rates identified in par. (a) shall apply during a specified period which shall not be less than one calendar month.

(2) RATE VARIANCE RESTRICTION. (a) For a new policy issued on or after March 15, 1992, the following table lists the maximum percent a rate may vary from the midpoint rate applicable to policies with the same case characteristics and benefit design characteristics according to the effective date of any rate applied to that policy:

EFFECTIVE DATE OF RATE	MAXIMUM VARIANCE FROM MIDPOINT RATE
1. March 15, 1992–August 14, 1994	35%
2. August 15, 1994 and after	30%

(b) For a policy issued before March 15, 1992, an insurer shall comply with the rate variance restriction specified in par. (a) 2 no later than August 15, 1994

(3) PREMIUM RATE CHANGES; DOCUMENTATION AND RESTRICTIONS. (a) For the purpose of complying with s. 635.02 (2), Stats., and this subsection,"class of business" means a group of policies with the same or similar benefit design whose rates are based wholly or partly on their aggregate loss experience.

(b) For a policy renewed on or after March 15, 1993, an insurer shall maintain sufficient documentation so that each of the following distinct components can be identified:

1. The percentage change in the new business premium rate measured from the rating period in which the small employer was last rated to the current rating period or, in the case of a class of business for which the insurer is not issuing new policies, the corresponding change in the base premium rate.

2. The percentage change due to adjustments in case characteristics, determined in accordance with the insurer's rate manual or rating procedures.

3. The percentage change due to adjustments in benefit design, determined in accordance with the insurer's rate manual or rating procedures.

4. The percentage change due to such rating factors as claim experience, health status and duration of coverage, determined in accordance with the insurer's rate manual or rating procedures.

(c) Each renewal rate, regardless of whether the rate represents an increase, shall be limited to the previous rate adjusted by the combination of the 4 components specified in par. (b) with the following restrictions on the experience component specified in par. (b) 4:

1. For a policy issued on or after March 15, 1992, the experience component shall be limited to 15% per year, adjusted proportionately for rating periods of less than one year.

2. For a policy issued before March 15, 1992, subd. 1. applies, except if the premium rate exceeds the midpoint rate by more than the percentage specified in sub. (2) (a) for the applicable period for policies with the same case characteristics and benefit design characteristics, the experience component may not exceed 0%.

(d) For a rate change 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:

1. The new business rate change component specified in par. (b) 1. may not be applied at that time.

2. The experience component specified in par. (b) 4. may not exceed 15% per year, adjusted proportionately to the time remaining in the policy term.

3. The experience component specified in par. (b) 4., when combined with the experience component of the last scheduled rate renewal and any other subsequent rate changes during the current policy term, shall not exceed the limit specified in par. (c) 1. or 2., whichever applies.

History: Cr. Register, October, 1992, No. 442, eff. 11–1–92; am. (3) (d) (intro.), Register, November, 1993, No. 455, eff. 2–1–94.

Ins 8.54 Guaranteed renewability; cancellation and renewal restrictions. (1) DEFINITION. (a) In this section, "medically underwritten policy" means a policy that is issued after the small employer insurer has, for purposes of risk selection, used information about the group's claim experience or the health history or medical records of one or more persons eligible for coverage.

(b) Notwithstanding par. (a), a small employer insurer may apply medical underwriting standards to an individual who originally declined and later applies for coverage under a nonmedically underwritten policy without converting that policy to a medically underwritten policy.

(2) CLASS OF BUSINESS. (a) In this section, each of the following is a separate class of business, regardless of variations in policy forms, marketing methods or duration of coverage among small employers in the class of business:

1. All small employers with medically underwritten policies.

2. All small employers with policies that are not medically underwritten.

3. All small employers whose policies constitute a block of business assumed by the small employer insurer under a specific assumption treaty with an insurer that is not an affiliate.

(b) No small employer insurer may establish a class of business other than one specified in par. (a).

(3) GUARANTEED RENEWABILITY. Except as provided in s. 635.07, Stats., a policyholder has the right to renew a policy on the same terms subject to the premium rate restrictions specified in s. Ins 8.52 (3). The subsection does not prohibit a small employer insurer from offering a policyholder renewal with altered benefit design characteristics if the offer is available to all policyholders in the same class of business without regard to claim experience.

(4) 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 the 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 premium for the additional coverage at the rate in effect at the time the additional coverage is provided.

(b) A small employer insurer 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 less than 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.

(d) A small employer insurer that intends to terminate a policy under s. 635.07 (1) (a) to (c) or (e), Stats., shall comply with the notice requirements under s. 631.36 (2) (b) and (c), (4), (6) and (7), Stats.

(5) NONRENEWAL OF CLASS OF BUSINESS. (a) If a small employer insurer ceases to renew policies issued to all small employers in the same class of business under s. 635.07 (2), Stats., the small employer insurer may not establish any new class of business during the 5–year period beginning with the latest expiration date for policies in effect in the class of business that is not renewed.

(b) At least one year before a small employer insurer ceases to renew policies under s. 635.07 (2), Stats., the small employer insurer shall provide the office with all of the following information:

1. The reason for the decision not to renew.

2. The number of small employers and the total number of eligible employes affected by the decision not to renew.

3. The number of small employers in other classes of the small employer insurer's business that are not affected by the decision not to renew.

(c) The commissioner may order an examination under s. 601.43, Stats., in order to determine the premium rate history and obtain information on the profitability of the nonrenewed class of business.

(d) At least one year before a small employer insurer ceases to renew policies under s. 635.07 (2), Stats., the small employer insurer shall provide written notice of that intent to all affected small employers and the 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; am. (4) (a) to (c), Register, November, 1993, No. 455, eff. 2–1–94.

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.

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.

History: Cr. Register, November, 1993, No. 455, eff. 2–1–94.

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.

History: Cr. Register, November, 1993, No. 455, eff. 2–1–94.

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 a 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.

History: Cr. Register, November, 1993, No. 455, eff. 2–1–94.

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 [be] 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 December 1, 1993, 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.

History: Cr. Register, November, 1993, No. 455, eff. 12–1–93.

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).

History: Cr. Register, November, 1993, No. 455, eff. 2–1–94.

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.

History: Cr. Register, November, 1993, No. 455, eff. 2–1–94.

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).

History: Cr. Register, November, 1993, No. 455, eff. 2–1–94.

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 December 1, 1993.

(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).

History: Cr. Register, November, 1993, No. 455, eff. 12–1–93.

Ins 8.67 Restrictive riders prohibited. 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.

History: Cr. Register, November, 1993, No. 455, eff. 2–1–94.

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 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 February 1, 1994, 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, 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.

History: Cr. Register, November, 1993, No. 455, eff. 2−1−94.

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. 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. 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.

History: Cr. Register, November, 1993, No. 455, eff. 2–1–94.

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 copayments 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.

(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).

(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; cr. (3) (c), Register, November, 1993, No. 455, eff. 2–1–94.

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.