



State of Wisconsin  
2009 - 2010 LEGISLATURE

LRB-1538/02  
PJK:jld/bjk/nwn:ph  
P3  
stays

DOA:.....Willing, BB0426 - Health insurance reform initiatives  
FOR 2009-11 BUDGET -- NOT READY FOR INTRODUCTION

SA ✓  
X-ref ✓

do not  
insert

1 AN ACT relating to: the budget.

*Analysis by the Legislative Reference Bureau*  
**INSURANCE**

***Independent review***

Under current law, every insurer that issues a group or individual health benefit plan must have an internal grievance procedure under which an insured may submit a written grievance and a grievance panel must investigate the grievance and, if appropriate, take corrective action. In addition, every insurer that issues a group or individual health benefit plan must have an independent review procedure for review, after the internal grievance procedure has been exhausted, of certain decisions that are adverse to an insured. The adverse decision must relate to the insurer's denial of treatment or payment for treatment that the insurer determined was experimental or to the insurer's denial, reduction, or termination of a health care service or payment for a health care service on the basis that the health care service did not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness. An independent review may be conducted only by an independent review organization that has been certified by the Commissioner of Insurance (commissioner).

The bill adds the rescission of a policy or certificate and a coverage denial determination based on a preexisting condition exclusion to the types of adverse decisions that are eligible for review under a group or individual health benefit plan's independent review procedure. In addition, the bill requires every insurer that

Insert A-1

issues individual health benefit plans to report to the commissioner annually the number of individual health benefit plans issued by the insurer in the preceding year and the number of individual health benefit plans with respect to which the insurer initiated or completed a cancellation or rescission in the preceding year.

### ***Preexisting condition exclusions***

Under current law, an insurer may impose a preexisting condition exclusion for up to two years under an individual health insurance policy. Under a group health insurance policy, a preexisting condition exclusion generally may not exceed one year. Additionally, under a group health insurance policy, an insurer is limited to imposing a preexisting condition exclusion only with respect to conditions for which an insured received treatment, or for which treatment was recommended, within six months before the insured's coverage began. Under an individual health insurance policy, an insurer is not limited with respect to how long before an insured's coverage began a condition must have existed to be considered a preexisting condition for an exclusion, and current law does not specify that the insured must have received treatment, or that treatment must have been recommended, for the condition. Thus, an insurer is free to impose a preexisting condition exclusion under an individual health insurance policy for any condition that may have existed at any time during the insured's lifetime that the insurer believes the insured should have known existed or for which the insurer believes the insured should have sought treatment. This bill provides that under an individual health insurance policy, an insurer may impose a preexisting condition exclusion for up to one year for a condition for which an insured received treatment, or for which treatment was recommended, within one year before the insured's coverage began.

### ***Modifications at renewal of individual health insurance***

With some exceptions, an insurer must renew an individual health insurance policy at the option of the insured. At renewal, the insurer may modify the policy form on a uniform basis among all individuals with coverage under that policy form. The bill requires an insurer, at renewal of an individual health insurance policy and at the request of the insured, to issue comparable coverage to the insured that the insurer currently offers that has more limited benefits or a higher deductible or to provide a higher deductible under the insured's current coverage. If the insurer issues the alternative coverage, the insurer may not rate the coverage for any health status that did not apply when the insured applied for the original coverage. An insurer issuing individual policies must annually mail to each insured under an individual policy issued by the insurer a notice that informs the insured of his or her right to elect alternative coverage and that describes the alternatives available to the insured and the procedure for electing the alternative coverage.

### ***Uniform application for individual health insurance***

The bill requires the commissioner to promulgate rules prescribing uniform questions and the format for individual health insurance policy applications, which may not be more than ten pages long. After the effective date of the rules, all insurers offering individual health insurance policies must use the prescribed questions and format on an application for such a policy.

**Dependent coverage**

Under current law, if a health insurer covers a person as a dependent because the person is a full-time student, the health insurer must continue to cover that person if he or she ceases to be a full-time student due to a medically necessary leave of absence until the happening of one of a number of specified events, such as the person's obtaining other health care coverage or reaching the age at which coverage ends under the terms of the policy for a dependent who is covered because he or she is a full-time student. Current law, however, does not require a health insurer to cover a dependent of an insured up to any particular age or because a dependent is a full-time student.

This bill changes the requirement under current law with respect to covering dependents. Under the bill, a health insurer must offer and, if so requested, provide dependent coverage for any child of an insured, even if not a student, if the child is unmarried, is under 27 years old, does not have other health care coverage, and is not employed full time by an employer that offers health care coverage to its employees. The coverage requirement applies to all types of individual and group health insurance policies and plans, including those offered by the state, and to self-insured health plans of counties, cities, villages, towns, school districts, and the state.

For further information see the *state and local* fiscal estimate, which will be printed as an appendix to this bill.

**The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:**

**SECTION 1.** 111.91 (2) (nm) of the statutes is amended to read:

111.91 (2) (nm) The requirements related to continuing offering and providing coverage for a dependent student on a medical leave of absence under s. 632.895 (15)

**SECTION 2.** 601.41 (10) of the statutes is created to read:

601.41 (10) UNIFORM APPLICATION FOR INDIVIDUAL HEALTH INSURANCE POLICIES.

(a) The commissioner shall by rule prescribe uniform questions and the format for applications, which may not exceed 10 pages in length, for individual major medical health insurance policies.

(b) After the effective date of the rules promulgated under par. (a), an insurer may use only the prescribed questions and format for individual major medical health insurance policy applications. The commissioner shall publish a notice in the

Insert A-2

Insert B-3

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11

plain  
of the Department of Health Services  
for s. 632.895(15)

1 Wisconsin Administrative Register that states the effective date of the rules  
2 promulgated under par. (a).

3 (c) For purposes of this subsection, an individual major medical health  
4 insurance policy includes health coverage provided on an individual basis through  
5 an association.

6 SECTION 3. 601.428 of the statutes is created to read:

7 **601.428 Cancellation and rescission reports.** Beginning in 2009, every  
8 insurer that issues individual health insurance policies shall annually report to the  
9 commissioner the total number of individual health insurance policies that the  
10 insurer issued in the preceding year and the total number of individual health  
11 insurance policies with respect to which the insurer initiated or completed a  
12 cancellation or rescission in the preceding year.

13 SECTION 4. 609.76 (title) of the statutes is amended to read:

14 **609.76 (title) Coverage of student on medical leave dependents.**

15 SECTION 5. 632.7497 of the statutes is created to read:

16 **632.7497 Modifications at renewal.** (1) In this section, "individual major  
17 medical or comprehensive health benefit plan" includes coverage under a group  
18 health benefit plan that is underwritten on an individual basis and issued to  
19 individuals or families.

20 (2) An insurer that issues an individual major medical or comprehensive  
21 health benefit plan shall, at the time of a coverage renewal, at the request of an  
22 insured, permit the insured to do either of the following:

23 (a) Change his or her coverage to a different but comparable individual major  
24 medical or comprehensive health benefit plan currently offered by the insurer with  
25 more limited benefits or with a higher deductible.

Insert 4-14

9

4 10

any of the following

Insert 4-25

1 (b) Modify his or her existing coverage by electing an optional higher  
2 deductible, if any, under the individual major medical or comprehensive health  
3 benefit plan.

4 (3) (a) The insurer may not impose any new preexisting condition exclusion  
5 under the new or modified coverage under sub. (2) that did not apply to the insured's  
6 original coverage and shall allow the insured credit under the new or modified  
7 coverage for the period of original coverage.

8 (b) For the new or modified coverage, the insurer may not rate for health status  
9 other than on the insured's health status at the time the insured applied for the  
10 original coverage and as the insured disclosed on the original application.

11 (4) (a) Annually, the insurer shall mail to each insured under an individual  
12 major medical or comprehensive health benefit plan issued by the insurer, a notice  
13 that includes all of the following information:

14 1. That the insured has the right to elect alternative coverage as described in  
15 sub. (2).

16 2. A description of the alternatives available to the insured.

17 3. The procedure for making the election.

18 (b) The insurer shall mail the notice under par. (a) not more than 3 months nor  
19 less than 60 days before the renewal date of the insured's plan.

20 (5) (a) Nothing in this section requires an insurer to issue alternative coverage  
21 under sub. (2) if the insured's coverage may be nonrenewed or discontinued under  
22 s. 632.7495 (2), (3) (b), or (4).

23 (b) Notwithstanding s. 600.01 (1) (b) 3. and 4., this section applies to a group  
24 health benefit plan described in s. 600.01 (1) (b) 3. or 4. if that group health benefit

1 plan is an individual major medical or comprehensive health benefit plan as defined  
2 in sub. (1).

3 SECTION 6. 632.76 (2) (a) of the statutes is amended to read:

4 632.76 (2) (a) No claim for loss incurred or disability commencing after 2 years  
5 12 months from the date of issue of the policy may be reduced or denied on the ground  
6 that a disease or physical condition existed prior to the effective date of coverage,  
7 unless the condition was excluded from coverage by name or specific description by  
8 a provision effective on the date of loss. This paragraph does not apply to a group  
9 health benefit plan, as defined in s. 632.745 (9), which is subject to s. 632.746.

10 SECTION 7. 632.76 (2) (ac) of the statutes is created to read:

11 632.76 (2) (ac) An individual disability insurance policy, as defined in s.  
12 632.895 (1) (a), may not define a preexisting condition more restrictively than a  
13 condition for which medical advice was given or treatment was recommended by or  
14 received from a physician within 12 months before the effective date of coverage.

Insert 6-14

15 SECTION 8. 632.76 (2) (b) of the statutes is amended to read:

16 632.76 (2) (b) Notwithstanding par. (a), no claim for loss incurred or disability  
17 commencing after 6 months from the date of issue of a medicare supplement policy,  
18 medicare replacement policy or long-term care insurance policy may be reduced or  
19 denied on the ground that a disease or physical condition existed prior to the effective  
20 date of coverage. -A- Notwithstanding par. (ac), a medicare supplement policy,  
21 medicare replacement policy, or long-term care insurance policy may not define a  
22 preexisting condition more restrictively than a condition for which medical advice  
23 was given or treatment was recommended by or received from a physician within 6  
24 months before the effective date of coverage. Notwithstanding par. (a), if on the basis  
25 of information contained in an application for insurance a medicare supplement

1 policy, medicare replacement policy, or long-term care insurance policy excludes  
2 from coverage a condition by name or specific description, the exclusion must  
3 terminate no later than 6 months after the date of issue of the medicare supplement  
4 policy, medicare replacement policy, or long-term care insurance policy. The  
5 commissioner may by rule exempt from this paragraph certain classes of medicare  
6 supplement policies, medicare replacement policies, and long-term care insurance  
7 policies, if the commissioner finds the exemption is not adverse to the interests of  
8 policyholders and certificate holders.

9 SECTION 9. 632.835 (title) of the statutes is amended to read:

10 **632.835 (title) Independent review of adverse and experimental**  
11 **treatment coverage denial determinations.**

12 SECTION 10. 632.835 (1) (ag) of the statutes is created to read:

13 632.835 (1) (ag) "Coverage denial determination" means an adverse  
14 determination, an experimental treatment determination, a preexisting condition  
15 exclusion denial determination, or the rescission of a policy or certificate.

16 SECTION 11. 632.835 (1) (cm) of the statutes is created to read:

17 632.835 (1) (cm) "Preexisting condition exclusion denial determination" means  
18 a determination by or on behalf of an insurer that issues a health benefit plan  
19 denying or terminating treatment or payment for treatment on the basis of a  
20 preexisting condition exclusion, as defined in s. 632.745 (23).

21 SECTION 12. 632.835 (2) (a) of the statutes is amended to read:

22 632.835 (2) (a) Every insurer that issues a health benefit plan shall establish  
23 an independent review procedure whereby an insured under the health benefit plan,  
24 or his or her authorized representative, may request and obtain an independent

1 review of an ~~adverse determination or an experimental treatment~~ a coverage denial  
2 determination made with respect to the insured.

3 **SECTION 13.** 632.835 (2) (b) of the statutes is amended to read:

4 632.835 (2) (b) If an ~~adverse determination or an experimental treatment~~ a  
5 coverage denial determination is made, the insurer involved in the determination  
6 shall provide notice to the insured of the insured's right to obtain the independent  
7 review required under this section, how to request the review, and the time within  
8 which the review must be requested. The notice shall include a current listing of  
9 independent review organizations certified under sub. (4). An independent review  
10 under this section may be conducted only by an independent review organization  
11 certified under sub. (4) and selected by the insured.

12 **SECTION 14.** 632.835 (2) (bg) 3. of the statutes is amended to read:

13 632.835 (2) (bg) 3. For any ~~adverse determination or experimental treatment~~  
14 coverage denial determination for which an explanation of benefits is not provided  
15 to the insured, the insurer provides a notice that the insured may have a right to an  
16 independent review after the internal grievance process and that an insured may be  
17 entitled to expedited, independent review with respect to an urgent matter. The  
18 notice shall also include a reference to the section of the policy or certificate that  
19 contains the description of the independent review procedure as required under  
20 subd. 1. The notice shall provide a toll-free telephone number and website, if  
21 appropriate, where consumers may obtain additional information regarding  
22 internal grievance and independent review processes.

23 **SECTION 15.** 632.835 (2) (c) of the statutes is amended to read:

24 632.835 (2) (c) Except as provided in par. (d), an insured must exhaust the  
25 internal grievance procedure under s. 632.83 before the insured may request an

1 independent review under this section. Except as provided in sub. (9) (a), an insured  
2 who uses the internal grievance procedure must request an independent review as  
3 provided in sub. (3) (a) within 4 months after the insured receives notice of the  
4 disposition of his or her grievance under s. 632.83 (3) (d).

5 **SECTION 16.** 632.835 (2) (e) of the statutes is created to read:

6 632.835 (2) (e) Nothing in this section requires an insured to request an  
7 independent review before commencing a civil action relating to a coverage denial  
8 determination.

9 **SECTION 17.** 632.835 (3) (a) of the statutes is amended to read:

10 632.835 (3) (a) To request an independent review, an insured or his or her  
11 authorized representative shall provide timely written notice of the request for  
12 independent review, and of the independent review organization selected, to the  
13 insurer that made or on whose behalf was made the adverse or experimental  
14 treatment coverage denial determination. The insurer shall immediately notify the  
15 commissioner and the independent review organization selected by the insured of  
16 the request for independent review. ~~The insured or his or her authorized~~  
17 ~~representative must pay a \$25 fee to the independent review organization. If the~~  
18 ~~insured prevails on the review, in whole or in part, the entire amount paid by the~~  
19 ~~insured or his or her authorized representative shall be refunded by the insurer to~~  
20 ~~the insured or his or her authorized representative.~~ For each independent review in  
21 which it is involved, an insurer shall pay a fee to the independent review  
22 organization.

23 **SECTION 18.** 632.835 (3) (e) of the statutes is amended to read:

24 632.835 (3) (e) In addition to the information under pars. (b) and (c), the  
25 independent review organization may accept for consideration any typed or printed,

1 verifiable medical or scientific evidence that the independent review organization  
2 determines is relevant, regardless of whether the evidence has been submitted for  
3 consideration at any time previously. The insurer and the insured shall submit to  
4 the other party to the independent review any information submitted to the  
5 independent review organization under this paragraph and pars. (b) and (c). If, on  
6 the basis of any additional information, the insurer reconsiders the insured's  
7 grievance and determines that the treatment that was the subject of the grievance  
8 should be covered, or that the policy or certificate that was rescinded should be  
9 reinstated, the independent review is terminated.

10 **SECTION 19.** 632.835 (3) (f) of the statutes is renumbered 632.835 (3) (f) 1. and  
11 amended to read:

12 632.835 (3) (f) 1. If the independent review is not terminated under par. (e), the  
13 independent review organization shall, within 30 business days after the expiration  
14 of all time limits that apply in the matter, make a decision on the basis of the  
15 documents and information submitted under this subsection. The decision shall be  
16 in writing, signed on behalf of the independent review organization and served by  
17 personal delivery or by mailing a copy to the insured or his or her authorized  
18 representative and to the insurer. ~~A~~ Except as provided in subd. 2., a decision of an  
19 independent review organization is binding on the insured and the insurer.

20 **SECTION 20.** 632.835 (3) (f) 2. of the statutes is created to read:

21 632.835 (3) (f) 2. A decision of an independent review organization regarding  
22 a preexisting condition exclusion denial determination or a rescission is not binding  
23 on the insured.

24 **SECTION 21.** 632.835 (3m) (a) of the statutes is amended to read:

1           632.835 (3m) (a) A decision of an independent review organization regarding  
2           an adverse determination or a preexisting condition exclusion denial determination  
3           must be consistent with the terms of the health benefit plan under which the adverse  
4           determination or preexisting condition exclusion denial determination was made.

5           **SECTION 22.** 632.835 (6m) (a) of the statutes is amended to read:

6           632.835 (6m) (a) ~~Be~~ Unless the review relates to a rescission, be a health care  
7           provider who is expert in treating the medical condition that is the subject of the  
8           review and who is knowledgeable about the treatment that is the subject of the  
9           review through current, actual clinical experience.

10          **SECTION 23.** 632.835 (7) (b) of the statutes is amended to read:

11          632.835 (7) (b) A health benefit plan that is the subject of an independent  
12          review and the insurer that issued the health benefit plan shall not be liable to any  
13          person for damages attributable to the insurer's or plan's actions taken in compliance  
14          with any decision regarding an adverse determination or an experimental treatment  
15          determination rendered by a certified independent review organization.

16          **SECTION 24.** 632.835 (8) of the statutes is renumbered 632.835 (8) (a) and  
17          amended to read:

18          632.835 (8) (a) Adverse and experimental treatment determinations. The  
19          commissioner shall make a determination that at least one independent review  
20          organization has been certified under sub. (4) that is able to effectively provide the  
21          independent reviews required under this section for adverse determinations and  
22          experimental treatment determinations and shall publish a notice in the Wisconsin  
23          Administrative Register that states a date that is 2 months after the commissioner  
24          makes that determination. The date stated in the notice shall be the date on which

1 the independent review procedure under this section begins operating with respect  
2 to adverse determinations and experimental treatment determinations.

3 **SECTION 25.** 632.835 (8) (b) of the statutes is created to read:

4 632.835 (8) (b) *Preexisting condition exclusion denials and rescissions.* The  
5 commissioner shall make a determination that at least one independent review  
6 organization has been certified under sub. (4) that is able to effectively provide the  
7 independent reviews required under this section for preexisting condition exclusion  
8 denial determinations and rescissions and shall publish a notice in the Wisconsin  
9 Administrative Register that states a date that is 2 months after the commissioner  
10 makes that determination. The date stated in the notice shall be the date on which  
11 the independent review procedure under this section begins operating with respect  
12 to preexisting condition exclusion denial determinations and rescissions.

13 **SECTION 26.** 632.835 (9) of the statutes is renumbered 632.835 (9) (a) and  
14 amended to read:

15 632.835 (9) (a) *Adverse and experimental treatment determinations.* The  
16 independent review required under this section with respect to an adverse  
17 determination or an experimental treatment determination shall be available to an  
18 insured who receives notice of the disposition of his or her grievance under s. 632.83  
19 (3) (d) on or after December 1, 2000. Notwithstanding sub. (2) (c), an insured who  
20 receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or  
21 after December 1, 2000, but before June 15, 2002, with respect to an adverse  
22 determination or an experimental treatment determination must request an  
23 independent review no later than 4 months after June 15, 2002.

24 **SECTION 27.** 632.835 (9) (b) of the statutes is created to read:

1           632.835 (9) (b) *Preexisting condition exclusion denials and rescissions.* The  
2 independent review required under this section with respect to a preexisting  
3 condition exclusion denial determination or a rescission shall be available to an  
4 insured who receives notice of the disposition of his or her grievance under s. 632.83  
5 (3) (d) on or after the date stated in the notice published in the Wisconsin  
6 Administrative Register by the commissioner under sub. (8) (b).

7           **SECTION 28.** 632.895 (15) (a) of the statutes is amended to read:

8           632.895 (15) (a) Subject to ~~pars. (b) and par. (c)~~, every insurer that issues a  
9 disability insurance policy, and every self-insured health plan of the state or a  
10 county, city, town, village, or school district, that provides coverage for a person as  
11 a dependent of the insured because the person is a full-time student shall continue  
12 to offer and, if so requested by an applicant or an insured, provide dependent  
13 coverage for the person if, due to a medically necessary leave of absence, he or she  
14 ceases to be a full-time student a child of the applicant or insured.

15           **SECTION 29.** 632.895 (15) (b) of the statutes is repealed.

16           **SECTION 30.** 632.895 (15) (c) (intro.) of the statutes is amended to read:

17           632.895 (15) (c) (intro.) A policy or plan is not required to ~~continue~~ provide the  
18 coverage under par. (a) only until if any of the following occurs applies:

19           **SECTION 31.** 632.895 (15) (c) 1. of the statutes is repealed.

20           **SECTION 32.** 632.895 (15) (c) 2. of the statutes is amended to read:

21           632.895 (15) (c) 2. The ~~person becomes~~ child is employed full time and his or  
22 her employer offers health care coverage to its employees.

23           **SECTION 33.** 632.895 (15) (c) 3. of the statutes is amended to read:

24           632.895 (15) (c) 3. The ~~person obtains~~ child has other health care coverage.

25           **SECTION 34.** 632.895 (15) (c) 4. of the statutes is amended to read:

Insert 13-6

1           632.895 (15) (c) 4. ~~The person marries and is eligible for coverage under his or~~  
2 ~~her spouse's health care coverage~~ child is married.

3           **SECTION 35.** 632.895 (15) (c) 5. of the statutes is amended to read:

4           632.895 (15) (c) 5. The person reaches the child is 27 years of age at which  
5 ~~coverage as a dependent who is a full-time student would otherwise end under the~~  
6 ~~terms and conditions of the policy or plan~~ or older.

7           **SECTION 36.** 632.895 (15) (c) 6. of the statutes is amended to read:

8           632.895 (15) (c) 6. Coverage of the insured through whom the person child has  
9 dependent coverage under the policy or plan is discontinued or not renewed.

10          **SECTION 37.** 632.895 (15) (c) 7. of the statutes is repealed.

11          **SECTION 9126. Nonstatutory provisions; Insurance.**

12          (1) RULES FOR UNIFORM APPLICATION. The commissioner of insurance shall  
13 submit in proposed form the rules required under section 601.41 (10) (a) of the  
14 statutes, as created by this act, to the legislative council staff under section 227.15  
15 (1) of the statutes no later than the first day of the 12th month beginning after the  
16 effective date of this subsection.

17          **SECTION 9326. Initial applicability; Insurance.**

18          (1) MODIFICATIONS AT RENEWAL. The treatment of section 632.7497 of the  
19 statutes first applies to individual major medical or comprehensive health benefit  
20 plans that are renewed on the effective date of this subsection.

21          (2) PREEXISTING CONDITION EXCLUSIONS. The treatment of section 632.76 (2) (a),  
22 (ac), and (b) of the statutes first applies to individual disability insurance policies  
23 that are issued or renewed on the effective date of this subsection.

1 (3) DEPENDENT COVERAGE. The treatment of sections 111.91 (2) (nm), 609.76  
 2 (title), and 632.895 (15) (a), (b), and (c) (intro.), 1., 2., 3., 4., 5., 6., and 7. of the statutes

3 first applies to all of the following:

4 (a) Except as provided in paragraphs (b) and (c), disability insurance policies  
 5 that are issued or renewed, and governmental or school district self-insured health  
 6 plans that are established, extended, modified, or renewed, on the effective date of  
 7 this paragraph.

8 (b) Disability insurance policies covering employees who are affected by a  
 9 collective bargaining agreement containing provisions inconsistent with this act  
 10 that are issued or renewed on the earlier of the following:

- 11 1. The day on which the collective bargaining agreement expires.
- 12 2. The day on which the collective bargaining agreement is extended, modified,  
 13 or renewed.

14 (c) Governmental or school district self-insured health plans covering  
 15 employees who are affected by a collective bargaining agreement containing  
 16 provisions inconsistent with this act that are established, extended, modified, or  
 17 renewed on the earlier of the following:

- 18 1. The day on which the collective bargaining agreement expires.
- 19 2. The day on which the collective bargaining agreement is extended, modified,  
 20 or renewed.

21 **SECTION 9426. Effective dates; Insurance.**

22 (1) DEPENDENT COVERAGE. The treatment of sections 111.91 (2) (nm), 609.76  
 23 (title), and 632.895 (15) (a), (b), and (c) (intro.), 1., 2., 3., 4., 5., 6., and 7. of the statutes

1 and SECTION 9326 (3) of this act take effect on first day of the 7th month beginning  
2 after publication.

3 (END)

2009-2010 DRAFTING INSERT  
FROM THE  
LEGISLATIVE REFERENCE BUREAU

LRB-1538/P3ins

PJK:.....

INSERT A-1

*NOT*  
The bill also eliminates the \$25 fee that an insured must pay when requesting an independent review.

(END OF INSERT A-1)

INSERT A-2

*+* Current law contains a number of provisions related to coverage of dependents under health insurance policies. For example, a health insurer must cover a newly born child of an insured from the moment of birth, but may discontinue coverage after 60 days if the insured does not notify the insurer of the birth and pay any additional premium within those 60 days. If a health insurer covers a child of an insured, the health insurer must also cover any child of the insured's child until the insured's child is 18 years old. If a health insurer covers dependents up to a certain age, the health insurer may not terminate coverage of a dependent child who reaches that age if, and while, the child is incapable of self-sustaining employment because of mental retardation or physical handicap and is dependent on the insured for support and maintenance. If a health insurer covers a person as a dependent because the person is a full-time student, the health insurer must continue to cover that person if he or she ceases to be a full-time student due to a medically necessary leave of absence until the happening of one of a number of specified events, such as the person's obtaining other health care coverage or reaching the age at which coverage ends under the terms of the policy for a dependent who is covered because he or she is a full-time student. Current law, however, does not require a health insurer to cover a dependent of an insured up to any particular age or because a dependent is a full-time student.

*+* Under this bill, a health insurer that provides coverage for dependents must cover any child of an insured if the child is unmarried, is under 27 years old, does not have other health care coverage, and is not employed full time by an employer that offers health care coverage to its employees. *NOT*

(END OF INSERT A-2)

INSERT 3-3

1

*X*  
SECTION 1. 111.91 (2) (nm) of the statutes is amended to read:

*Ins 3-3*

1           111.91 (2) (nm) The requirements related to providing coverage for a dependent  
2           under s. 632.895 (14m) and to continuing coverage for a dependent student on a  
3           medical leave of absence under s. 632.895 (15).

History: 1971 c. 270; 1975 c. 39, 224; 1977 c. 196; 1979 c. 221; 1983 a. 27; 1985 a. 42; 1987 a. 27, 287, 331; 1989 a. 13, 31, 323; 1991 a. 269, 289; 1995 a. 27, 289; 1995 a. 302 s. 48; 1997 a. 27, 35, 155, 237; 1999 a. 9, 95, 115, 155; 2001 a. 16, 26; 2003 a. 33; 2007 a. 36.

(END OF INSERT 3-3)

INSERT 4-14

(END OF INSERT 4-14)

*X*

4           **SECTION 2.** 609.755 of the statutes is created to read:

5           **609.755 Coverage of dependents.** Limited service health organizations,  
6           preferred provider plans, and defined network plans are subject to s. 632.895 (14m).

INSERT 4-25

7           *FF* 2. An individual major medical or comprehensive health benefit plan currently  
8           offered by the insurer with more limited benefits.

9           *FF* 3. An individual major medical or comprehensive health benefit plan currently  
10          offered by the insurer with higher deductibles.

(END OF INSERT 4-25)

INSERT 6-14

11          *wff* condition, whether physical or mental, regardless of the cause of the condition,  
12          for which medical advice, diagnosis, care, or treatment was recommended or received

(END OF INSERT 6-14)

INSERT 9-7

13          *wff* affects an insured's right to commence a civil proceeding

(END OF INSERT 9-7)

INSERT 13-6

X Ins 13-16

(a)

Subject to para (b)

1

SECTION 3. 632.895 (14m) of the statutes is created to read:

2

632.895 (14m) COVERAGE OF DEPENDENTS. Every disability insurance policy,

3

and every self-insured health plan of the state or a county, city, town, village, or

4

school district, that provides coverage for a person as a dependent of the insured shall

5

provide dependent coverage for a child of the insured, unless any of the following

6

applies:

7

10 (a) The child is 27 years of age or older.

8

20 (b) The child is married.

9

30 (c) The child has other health care coverage.

10

40 (d) The child is employed full time and his or her employer offers health care

11

coverage to its employees.

12

50 (e) Coverage of the insured through whom the child has dependent coverage

13

under the policy or plan is discontinued or not renewed.

(END OF INSERT 13-6)

(b) A policy or plan ~~is~~ is not required to provide dependent coverage for a child of an insured if ~~is~~ is not required to provide dependent coverage for a child of an insured if



State of Wisconsin  
2009 - 2010 LEGISLATURE

LRB-1538/P3  
PJK:jld/bjk/nwn:jf

DOA:.....Willing, BB0426 - Health insurance reform initiatives

FOR 2009-11 BUDGET -- NOT READY FOR INTRODUCTION

1 AN ACT ...; relating to: the budget.

---

*Analysis by the Legislative Reference Bureau*

**INSURANCE**

***Independent review***

Under current law, every insurer that issues a group or individual health benefit plan must have an internal grievance procedure under which an insured may submit a written grievance and a grievance panel must investigate the grievance and, if appropriate, take corrective action. In addition, every insurer that issues a group or individual health benefit plan must have an independent review procedure for review, after the internal grievance procedure has been exhausted, of certain decisions that are adverse to an insured. The adverse decision must relate to the insurer's denial of treatment or payment for treatment that the insurer determined was experimental or to the insurer's denial, reduction, or termination of a health care service or payment for a health care service on the basis that the health care service did not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness. An independent review may be conducted only by an independent review organization that has been certified by the Commissioner of Insurance (commissioner).

The bill adds the rescission of a policy or certificate and a coverage denial determination based on a preexisting condition exclusion to the types of adverse decisions that are eligible for review under a group or individual health benefit plan's independent review procedure. The bill also eliminates the \$25 fee that an insured

must pay when requesting an independent review. In addition, the bill requires every insurer that issues individual health benefit plans to report to the commissioner annually the number of individual health benefit plans issued by the insurer in the preceding year and the number of individual health benefit plans with respect to which the insurer initiated or completed a cancellation or rescission in the preceding year.

#### ***Preexisting condition exclusions***

Under current law, an insurer may impose a preexisting condition exclusion for up to two years under an individual health insurance policy. Under a group health insurance policy, a preexisting condition exclusion generally may not exceed one year. Additionally, under a group health insurance policy, an insurer is limited to imposing a preexisting condition exclusion only with respect to conditions for which an insured received treatment, or for which treatment was recommended, within six months before the insured's coverage began. Under an individual health insurance policy, an insurer is not limited with respect to how long before an insured's coverage began a condition must have existed to be considered a preexisting condition for an exclusion, and current law does not specify that the insured must have received treatment, or that treatment must have been recommended, for the condition. Thus, an insurer is free to impose a preexisting condition exclusion under an individual health insurance policy for any condition that may have existed at any time during the insured's lifetime that the insurer believes the insured should have known existed or for which the insurer believes the insured should have sought treatment. This bill provides that under an individual health insurance policy, an insurer may impose a preexisting condition exclusion for up to one year for a condition for which an insured received treatment, or for which treatment was recommended, within one year before the insured's coverage began.

#### ***Modifications at renewal of individual health insurance***

With some exceptions, an insurer must renew an individual health insurance policy at the option of the insured. At renewal, the insurer may modify the policy form on a uniform basis among all individuals with coverage under that policy form. The bill requires an insurer, at renewal of an individual health insurance policy and at the request of the insured, to issue comparable coverage to the insured that the insurer currently offers that has more limited benefits or a higher deductible or to provide a higher deductible under the insured's current coverage. If the insurer issues the alternative coverage, the insurer may not rate the coverage for any health status that did not apply when the insured applied for the original coverage. An insurer issuing individual policies must annually mail to each insured under an individual policy issued by the insurer a notice that informs the insured of his or her right to elect alternative coverage and that describes the alternatives available to the insured and the procedure for electing the alternative coverage.

#### ***Uniform application for individual health insurance***

The bill requires the commissioner to promulgate rules prescribing uniform questions and the format for individual health insurance policy applications, which may not be more than ten pages long. After the effective date of the rules, all insurers

offering individual health insurance policies must use the prescribed questions and format on an application for such a policy.

***Dependent coverage***

Current law contains a number of provisions related to coverage of dependents under health insurance policies. For example, a health insurer must cover a newly born child of an insured from the moment of birth, but may discontinue coverage after 60 days if the insured does not notify the insurer of the birth and pay any additional premium within those 60 days. If a health insurer covers a child of an insured, the health insurer must also cover any child of the insured's child until the insured's child is 18 years old. If a health insurer covers dependents up to a certain age, the health insurer may not terminate coverage of a dependent child who reaches that age if, and while, the child is incapable of self-sustaining employment because of mental retardation or physical handicap and is dependent on the insured for support and maintenance. If a health insurer covers a person as a dependent because the person is a full-time student, the health insurer must continue to cover that person if he or she ceases to be a full-time student due to a medically necessary leave of absence until the happening of one of a number of specified events, such as the person's obtaining other health care coverage or reaching the age at which coverage ends under the terms of the policy for a dependent who is covered because he or she is a full-time student. Current law, however, does not require a health insurer to cover a dependent of an insured up to any particular age or because a dependent is a full-time student.

Under this bill, a health insurer that provides coverage for dependents must cover any child of an insured if the child is unmarried, is under 27 years old, does not have other health care coverage, and is not employed full time by an employer that offers health care coverage to its employees. The coverage requirement applies to all types of individual and group health insurance policies and plans, including those offered by the state, and to self-insured health plans of counties, cities, villages, towns, school districts, and the state.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

---

***The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:***

- 1           **SECTION 1.** 111.91 (2) (nm) of the statutes is amended to read:
- 2           111.91 (2) (nm) The requirements related to providing coverage for a dependent
- 3 under s. 632.895 (14m) and to continuing coverage for a dependent student on a
- 4 medical leave of absence under s. 632.895 (15).
- 5           **SECTION 2.** 601.41 (10) of the statutes is created to read:

1           **601.41 (10) UNIFORM APPLICATION FOR INDIVIDUAL HEALTH INSURANCE POLICIES.**

2           (a) The commissioner shall by rule prescribe uniform questions and the format for  
3 applications, which may not exceed 10 pages in length, for individual major medical  
4 health insurance policies.

5           (b) After the effective date of the rules promulgated under par. (a), an insurer  
6 may use only the prescribed questions and format for individual major medical  
7 health insurance policy applications. The commissioner shall publish a notice in the  
8 Wisconsin Administrative Register that states the effective date of the rules  
9 promulgated under par. (a).

10           (c) For purposes of this subsection, an individual major medical health  
11 insurance policy includes health coverage provided on an individual basis through  
12 an association.

13           **SECTION 3.** 601.428 of the statutes is created to read:

14           **601.428 Cancellation and rescission reports.** Beginning in 2009, every  
15 insurer that issues individual health insurance policies shall annually report to the  
16 commissioner the total number of individual health insurance policies that the  
17 insurer issued in the preceding year and the total number of individual health  
18 insurance policies with respect to which the insurer initiated or completed a  
19 cancellation or rescission in the preceding year.

20           **SECTION 4.** 609.755 of the statutes is created to read:

21           **609.755 Coverage of dependents.** Limited service health organizations,  
22 preferred provider plans, and defined network plans are subject to s. 632.895 (14m).

23           **SECTION 5.** 632.7497 of the statutes is created to read:

24           **632.7497 Modifications at renewal. (1)** In this section, "individual major  
25 medical or comprehensive health benefit plan" includes coverage under a group

1 health benefit plan that is underwritten on an individual basis and issued to  
2 individuals or families.

3 (2) An insurer that issues an individual major medical or comprehensive  
4 health benefit plan shall, at the time of a coverage renewal, at the request of an  
5 insured, permit the insured to do either of the following:

6 (a) Change his or her coverage to any of the following:

7 1. A different but comparable individual major medical or comprehensive  
8 health benefit plan currently offered by the insurer.

9 2. An individual major medical or comprehensive health benefit plan currently  
10 offered by the insurer with more limited benefits.

11 3. An individual major medical or comprehensive health benefit plan currently  
12 offered by the insurer with higher deductibles.

13 (b) Modify his or her existing coverage by electing an optional higher  
14 deductible, if any, under the individual major medical or comprehensive health  
15 benefit plan.

16 (3) (a) The insurer may not impose any new preexisting condition exclusion  
17 under the new or modified coverage under sub. (2) that did not apply to the insured's  
18 original coverage and shall allow the insured credit under the new or modified  
19 coverage for the period of original coverage.

20 (b) For the new or modified coverage, the insurer may not rate for health status  
21 other than on the insured's health status at the time the insured applied for the  
22 original coverage and as the insured disclosed on the original application.

23 (4) (a) Annually, the insurer shall mail to each insured under an individual  
24 major medical or comprehensive health benefit plan issued by the insurer, a notice  
25 that includes all of the following information:

1           1. That the insured has the right to elect alternative coverage as described in  
2 sub. (2).

3           2. A description of the alternatives available to the insured.

4           3. The procedure for making the election.

5           (b) The insurer shall mail the notice under par. (a) not more than 3 months nor  
6 less than 60 days before the renewal date of the insured's plan.

7           **(5)** (a) Nothing in this section requires an insurer to issue alternative coverage  
8 under sub. (2) if the insured's coverage may be nonrenewed or discontinued under  
9 s. 632.7495 (2), (3) (b), or (4).

10           (b) Notwithstanding s. 600.01 (1) (b) 3. and 4., this section applies to a group  
11 health benefit plan described in s. 600.01 (1) (b) 3. or 4. if that group health benefit  
12 plan is an individual major medical or comprehensive health benefit plan as defined  
13 in sub. (1).

14           **SECTION 6.** 632.76 (2) (a) of the statutes is amended to read:

15           632.76 (2) (a) No claim for loss incurred or disability commencing after 2 years  
16 12 months from the date of issue of the policy may be reduced or denied on the ground  
17 that a disease or physical condition existed prior to the effective date of coverage,  
18 unless the condition was excluded from coverage by name or specific description by  
19 a provision effective on the date of loss. This paragraph does not apply to a group  
20 health benefit plan, as defined in s. 632.745 (9), which is subject to s. 632.746.

21           **SECTION 7.** 632.76 (2) (ac) of the statutes is created to read:

22           632.76 (2) (ac) An individual disability insurance policy, as defined in s.  
23 632.895 (1) (a), may not define a preexisting condition more restrictively than a  
24 condition, whether physical or mental, regardless of the cause of the condition, for

1 which medical advice, diagnosis, care, or treatment was recommended or received  
2 within 12 months before the effective date of coverage.

3 **SECTION 8.** 632.76 (2) (b) of the statutes is amended to read:

4 632.76 (2) (b) Notwithstanding par. (a), no claim for loss incurred or disability  
5 commencing after 6 months from the date of issue of a medicare supplement policy,  
6 medicare replacement policy or long-term care insurance policy may be reduced or  
7 denied on the ground that a disease or physical condition existed prior to the effective  
8 date of coverage. ~~A~~ Notwithstanding par. (ac), a medicare supplement policy,  
9 medicare replacement policy, or long-term care insurance policy may not define a  
10 preexisting condition more restrictively than a condition for which medical advice  
11 was given or treatment was recommended by or received from a physician within 6  
12 months before the effective date of coverage. Notwithstanding par. (a), if on the basis  
13 of information contained in an application for insurance a medicare supplement  
14 policy, medicare replacement policy, or long-term care insurance policy excludes  
15 from coverage a condition by name or specific description, the exclusion must  
16 terminate no later than 6 months after the date of issue of the medicare supplement  
17 policy, medicare replacement policy, or long-term care insurance policy. The  
18 commissioner may by rule exempt from this paragraph certain classes of medicare  
19 supplement policies, medicare replacement policies, and long-term care insurance  
20 policies, if the commissioner finds the exemption is not adverse to the interests of  
21 policyholders and certificate holders.

22 **SECTION 9.** 632.835 (title) of the statutes is amended to read:

23 **632.835 (title) Independent review of adverse and experimental**  
24 **treatment coverage denial determinations.**

25 **SECTION 10.** 632.835 (1) (ag) of the statutes is created to read:

1           632.835 (1) (ag) “Coverage denial determination” means an adverse  
2 determination, an experimental treatment determination, a preexisting condition  
3 exclusion denial determination, or the rescission of a policy or certificate.

4           **SECTION 11.** 632.835 (1) (cm) of the statutes is created to read:

5           632.835 (1) (cm) “Preexisting condition exclusion denial determination” means  
6 a determination by or on behalf of an insurer that issues a health benefit plan  
7 denying or terminating treatment or payment for treatment on the basis of a  
8 preexisting condition exclusion, as defined in s. 632.745 (23).

9           **SECTION 12.** 632.835 (2) (a) of the statutes is amended to read:

10           632.835 (2) (a) Every insurer that issues a health benefit plan shall establish  
11 an independent review procedure whereby an insured under the health benefit plan,  
12 or his or her authorized representative, may request and obtain an independent  
13 review of ~~an adverse determination or an experimental treatment~~ a coverage denial  
14 determination made with respect to the insured.

15           **SECTION 13.** 632.835 (2) (b) of the statutes is amended to read:

16           632.835 (2) (b) If ~~an adverse determination or an experimental treatment~~ a  
17 coverage denial determination is made, the insurer involved in the determination  
18 shall provide notice to the insured of the insured’s right to obtain the independent  
19 review required under this section, how to request the review, and the time within  
20 which the review must be requested. The notice shall include a current listing of  
21 independent review organizations certified under sub. (4). An independent review  
22 under this section may be conducted only by an independent review organization  
23 certified under sub. (4) and selected by the insured.

24           **SECTION 14.** 632.835 (2) (bg) 3. of the statutes is amended to read:

1           632.835 (2) (bg) 3. For any ~~adverse determination or experimental treatment~~  
2           coverage denial determination for which an explanation of benefits is not provided  
3           to the insured, the insurer provides a notice that the insured may have a right to an  
4           independent review after the internal grievance process and that an insured may be  
5           entitled to expedited, independent review with respect to an urgent matter. The  
6           notice shall also include a reference to the section of the policy or certificate that  
7           contains the description of the independent review procedure as required under  
8           subd. 1. The notice shall provide a toll-free telephone number and website, if  
9           appropriate, where consumers may obtain additional information regarding  
10          internal grievance and independent review processes.

11           **SECTION 15.** 632.835 (2) (c) of the statutes is amended to read:

12           632.835 (2) (c) Except as provided in par. (d), an insured must exhaust the  
13          internal grievance procedure under s. 632.83 before the insured may request an  
14          independent review under this section. Except as provided in sub. (9) (a), an insured  
15          who uses the internal grievance procedure must request an independent review as  
16          provided in sub. (3) (a) within 4 months after the insured receives notice of the  
17          disposition of his or her grievance under s. 632.83 (3) (d).

18           **SECTION 16.** 632.835 (2) (e) of the statutes is created to read:

19           632.835 (2) (e) Nothing in this section affects an insured's right to commence  
20          a civil proceeding relating to a coverage denial determination.

21           **SECTION 17.** 632.835 (3) (a) of the statutes is amended to read:

22           632.835 (3) (a) To request an independent review, an insured or his or her  
23          authorized representative shall provide timely written notice of the request for  
24          independent review, and of the independent review organization selected, to the  
25          insurer that made or on whose behalf was made the ~~adverse or experimental~~

1 ~~treatment coverage denial~~ determination. The insurer shall immediately notify the  
2 commissioner and the independent review organization selected by the insured of  
3 the request for independent review. ~~The insured or his or her authorized~~  
4 ~~representative must pay a \$25 fee to the independent review organization. If the~~  
5 ~~insured prevails on the review, in whole or in part, the entire amount paid by the~~  
6 ~~insured or his or her authorized representative shall be refunded by the insurer to~~  
7 ~~the insured or his or her authorized representative.~~ For each independent review in  
8 which it is involved, an insurer shall pay a fee to the independent review  
9 organization.

10 **SECTION 18.** 632.835 (3) (e) of the statutes is amended to read:

11 632.835 (3) (e) In addition to the information under pars. (b) and (c), the  
12 independent review organization may accept for consideration any typed or printed,  
13 verifiable medical or scientific evidence that the independent review organization  
14 determines is relevant, regardless of whether the evidence has been submitted for  
15 consideration at any time previously. The insurer and the insured shall submit to  
16 the other party to the independent review any information submitted to the  
17 independent review organization under this paragraph and pars. (b) and (c). If, on  
18 the basis of any additional information, the insurer reconsiders the insured's  
19 grievance and determines that the treatment that was the subject of the grievance  
20 should be covered, or that the policy or certificate that was rescinded should be  
21 reinstated, the independent review is terminated.

22 **SECTION 19.** 632.835 (3) (f) of the statutes is renumbered 632.835 (3) (f) 1. and  
23 amended to read:

24 632.835 (3) (f) 1. If the independent review is not terminated under par. (e), the  
25 independent review organization shall, within 30 business days after the expiration

1 of all time limits that apply in the matter, make a decision on the basis of the  
2 documents and information submitted under this subsection. The decision shall be  
3 in writing, signed on behalf of the independent review organization and served by  
4 personal delivery or by mailing a copy to the insured or his or her authorized  
5 representative and to the insurer. ~~A~~ Except as provided in subd. 2., a decision of an  
6 independent review organization is binding on the insured and the insurer.

7 **SECTION 20.** 632.835 (3) (f) 2. of the statutes is created to read:

8 632.835 (3) (f) 2. A decision of an independent review organization regarding  
9 a preexisting condition exclusion denial determination or a rescission is not binding  
10 on the insured.

11 **SECTION 21.** 632.835 (3m) (a) of the statutes is amended to read:

12 632.835 (3m) (a) A decision of an independent review organization regarding  
13 an adverse determination or a preexisting condition exclusion denial determination  
14 must be consistent with the terms of the health benefit plan under which the adverse  
15 determination or preexisting condition exclusion denial determination was made.

16 **SECTION 22.** 632.835 (6m) (a) of the statutes is amended to read:

17 632.835 (6m) (a) ~~Be~~ Unless the review relates to a rescission, be a health care  
18 provider who is expert in treating the medical condition that is the subject of the  
19 review and who is knowledgeable about the treatment that is the subject of the  
20 review through current, actual clinical experience.

21 **SECTION 23.** 632.835 (7) (b) of the statutes is amended to read:

22 632.835 (7) (b) A health benefit plan that is the subject of an independent  
23 review and the insurer that issued the health benefit plan shall not be liable to any  
24 person for damages attributable to the insurer's or plan's actions taken in compliance

1 with any decision regarding an adverse determination or an experimental treatment  
2 determination rendered by a certified independent review organization.

3 **SECTION 24.** 632.835 (8) of the statutes is renumbered 632.835 (8) (a) and  
4 amended to read:

5 632.835 (8) (a) *Adverse and experimental treatment determinations.* The  
6 commissioner shall make a determination that at least one independent review  
7 organization has been certified under sub. (4) that is able to effectively provide the  
8 independent reviews required under this section for adverse determinations and  
9 experimental treatment determinations and shall publish a notice in the Wisconsin  
10 Administrative Register that states a date that is 2 months after the commissioner  
11 makes that determination. The date stated in the notice shall be the date on which  
12 the independent review procedure under this section begins operating with respect  
13 to adverse determinations and experimental treatment determinations.

14 **SECTION 25.** 632.835 (8) (b) of the statutes is created to read:

15 632.835 (8) (b) *Preexisting condition exclusion denials and rescissions.* The  
16 commissioner shall make a determination that at least one independent review  
17 organization has been certified under sub. (4) that is able to effectively provide the  
18 independent reviews required under this section for preexisting condition exclusion  
19 denial determinations and rescissions and shall publish a notice in the Wisconsin  
20 Administrative Register that states a date that is 2 months after the commissioner  
21 makes that determination. The date stated in the notice shall be the date on which  
22 the independent review procedure under this section begins operating with respect  
23 to preexisting condition exclusion denial determinations and rescissions.

24 **SECTION 26.** 632.835 (9) of the statutes is renumbered 632.835 (9) (a) and  
25 amended to read:

1           632.835 (9) (a) Adverse and experimental treatment determinations. The  
2 independent review required under this section with respect to an adverse  
3 determination or an experimental treatment determination shall be available to an  
4 insured who receives notice of the disposition of his or her grievance under s. 632.83  
5 (3) (d) on or after December 1, 2000. Notwithstanding sub. (2) (c), an insured who  
6 receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or  
7 after December 1, 2000, but before June 15, 2002, with respect to an adverse  
8 determination or an experimental treatment determination must request an  
9 independent review no later than 4 months after June 15, 2002.

10           **SECTION 27.** 632.835 (9) (b) of the statutes is created to read:

11           632.835 (9) (b) *Preexisting condition exclusion denials and rescissions.* The  
12 independent review required under this section with respect to a preexisting  
13 condition exclusion denial determination or a rescission shall be available to an  
14 insured who receives notice of the disposition of his or her grievance under s. 632.83  
15 (3) (d) on or after the date stated in the notice published in the Wisconsin  
16 Administrative Register by the commissioner under sub. (8) (b).

17           **SECTION 28.** 632.895 (14m) of the statutes is created to read:

18           632.895 (14m) **COVERAGE OF DEPENDENTS.** (a) Subject to par. (b), every disability  
19 insurance policy, and every self-insured health plan of the state or a county, city,  
20 town, village, or school district, that provides coverage for a person as a dependent  
21 of an insured shall provide dependent coverage for a child of an insured.

22           (b) A policy or plan is not required to provide dependent coverage for a child of  
23 an insured if any of the following applies:

- 24           1. The child is 27 years of age or older.
- 25           2. The child is married.

1           3. The child has other health care coverage.

2           4. The child is employed full time and his or her employer offers health care  
3 coverage to its employees.

4           5. Coverage of the insured through whom the child has dependent coverage  
5 under the policy or plan is discontinued or not renewed.

6           **SECTION 9126. Nonstatutory provisions; Insurance.**

7           (1) RULES FOR UNIFORM APPLICATION. The commissioner of insurance shall  
8 submit in proposed form the rules required under section 601.41 (10) (a) of the  
9 statutes, as created by this act, to the legislative council staff under section 227.15  
10 (1) of the statutes no later than the first day of the 12th month beginning after the  
11 effective date of this subsection.

12           **SECTION 9326. Initial applicability; Insurance.**

13           (1) MODIFICATIONS AT RENEWAL. The treatment of section 632.7497 of the  
14 statutes first applies to individual major medical or comprehensive health benefit  
15 plans that are renewed on the effective date of this subsection.

16           (2) PREEXISTING CONDITION EXCLUSIONS. The treatment of section 632.76 (2) (a),  
17 (ac), and (b) of the statutes first applies to individual disability insurance policies  
18 that are issued or renewed on the effective date of this subsection.

19           (3) DEPENDENT COVERAGE. The treatment of sections 111.91 (2) (nm), 609.755,  
20 and 632.895 (14m) of the statutes first applies to all of the following:

21           (a) Except as provided in paragraphs (b) and (c), disability insurance policies  
22 that are issued or renewed, and governmental or school district self-insured health  
23 plans that are established, extended, modified, or renewed, on the effective date of  
24 this paragraph.

