State of Wisconsin
1999 - 2000 LEGISLATURE

LRB-3798/1
PJK:wlj:hmh

1999 SENATE BILL 269

October 28, 1999 - Introduced by Senators BRESKE, CLAUSING, DRZEWIECKI, ROESSLER, SCHULTZ and ROSENZWEIG, cosponsored by Representatives UNDERHEIM, F. LASEE, MUSSER, ALBERS, LADWIG and URBAN. Referred to Committee on Health, Utilities, Veterans and Military Affairs.

AN ACT ***to repeal*** 609.15 (title) and (1) (intro.); ***to renumber*** 609.15 (1) (c), 609.15 (2) (c), 609.15 (2) (d) and 609.15 (2) (e); ***to renumber and amend*** 609.15 (1) (a), 609.15 (1) (b), 609.15 (2) (intro.), 609.15 (2) (a) and 609.15 (2) (b); ***to amend*** 40.51 (8), 40.51 (8m), 600.01 (2) (b), 601.42 (4) and 609.655 (4) (b); and ***to create*** 111.91 (2) (r), 601.31 (1) (Lp), 601.31 (1) (Lr), 632.83 and 632.835 of the statutes; **relating to:** requiring insurers to establish internal grievance procedures, independent review of certain coverage determinations made by health benefit plans and granting rule-making authority.

Analysis by the Legislative Reference Bureau

Under current law, every managed care plan is required to have an internal grievance procedure under which an enrollee may submit a written grievance and a grievance panel must investigate the grievance and, if appropriate, take corrective action. This bill requires every insurer that issues a health benefit plan to have such an internal grievance procedure. In addition, the bill requires every insurer that issues a health benefit plan, including a managed care plan or a plan covering state and municipal employes, to have an independent review procedure for review of certain decisions that are adverse to insureds. The 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, including admission to or continued stay in a health care facility, on the basis that the health care service did not meet the plan's requirements for medical necessity or appropriateness, health care setting or level of care or effectiveness. In order to be eligible for independent review, the amount of the reduction or the cost or expected cost of the denied or terminated service must be at least $500, which may be increased or decreased by the commissioner of insurance (commissioner) based on changes in the consumer price index. Generally, an insured must request independent review within four months after receiving notice of an adverse decision on his or her grievance under the internal grievance procedure.

Under the bill, an independent review may be conducted only by an independent review organization that has been certified by the commissioner. A certified independent review organization must be recertified every two years to continue to conduct independent reviews. The commissioner may revoke, suspend or limit the certification of an independent review organization for various reasons specified in the bill. Clinical peer reviewers, who conduct the reviews on behalf of independent review organizations, must be health care providers who satisfy specified criteria, including having expertise through current, actual clinical experience in treating the condition that is the subject of the review. The insured selects the independent review organization that will conduct the review.

Generally, an insured must exhaust the internal grievance procedure under the health benefit plan before he or she may request independent review. Exceptions are if the insured and insurer agree to bypass the internal grievance procedure or if the insured submits a request to the independent review organization for a bypass and the independent review organization determines that requiring the insured to use the internal grievance procedure would jeopardize the life or health of the insured or the insured's ability to regain maximum function.

To request an independent review, an insured must provide written notice of the request, and of the independent review organization selected, to the insurer issuing the health benefit plan, which must inform the commissioner and the independent review organization of the request. The insured must pay $50 to the independent review organization, which is refunded by the insurer to the insured if he or she prevails, in whole or in part, in the independent review. In addition, the insurer must pay a fee to the independent review organization for each review.

Within three days after receiving the notice from the insured, the insurer must send to the independent review organization all of the information that it used in making the determination in the internal grievance procedure. No later than five days after receiving that information, the independent review organization may request more information from either or both parties, who have five more days in which to supply the requested information. The independent review organization may consider, however, any other relevant information, and any information that a party provides to the independent review organization must also be provided to the other party. Within 30 days after the expiration of all relevant time limits in the matter, the independent review organization must make a determination on the

basis of the written information submitted by the parties. If an expedited review is required because of the insured's medical condition, all specified time limits are shortened, and the independent review organization must make a determination within 72 hours after the expiration of all relevant time limits in the matter. The bill specifies certain review standards for independent review organizations, including under what circumstances treatment that was considered experimental by the insurer issuing the health benefit plan must be covered. The decision at the conclusion of an independent review, which is binding on the insured and the insurer, must be in writing and served on both parties.

The bill contains prohibitions aimed at avoiding conflicts of interest for independent review organizations, such as prohibiting an independent review organization from owning, controlling or being a subsidiary of a health benefit plan or an association of health benefit plans. The bill also provides independent review organizations and clinical peer reviewers with immunity from liability for decisions made in independent reviews.

The bill requires the commissioner to promulgate rules relating to such topics as the application procedures and standards for certification and recertification of independent review organizations, additional procedures and processes that independent review organizations must use in independent reviews, standards for the practices and conduct of independent review organizations and additional standards related to conflicts of interest. The commissioner must also approve, on the basis of reasonableness, fees that independent review organizations charge for conducting independent reviews.

Finally, the bill requires the commissioner to determine when at least one independent review organization has been certified that is able to effectively provide the independent reviews required under the bill. When the commissioner makes that determination, the commissioner must publish a notice in the Wisconsin Administrative Register that specifies a date that is two months after the determination is made. That date is the date on which the independent review procedure must begin operating.

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. 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (5), 632.895 (5m) and (8) to (13) and 632.896.

SECTION 2. 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855 and 632.895 (11) to (13).

SECTION 3. 111.91 (2) (r) of the statutes is created to read:

111.91 **(2)** (r) The requirements related to internal grievance procedures under s. 632.83 and independent review of certain health benefit plan determinations under s. 632.835.

SECTION 4. 600.01 (2) (b) of the statutes is amended to read:

600.01 **(2)** (b) Group or blanket insurance described in sub. (1) (b) 3. and 4. is not exempt from ss. 632.745 to 632.749, 632.83 or 632.835 or ch. 633 or 635.

SECTION 5. 601.31 (1) (Lp) of the statutes is created to read:

601.31 **(1)** (Lp) For certifying as an independent review organization under s. 632.835, $400.

SECTION 6. 601.31 (1) (Lr) of the statutes is created to read:

601.31 **(1)** (Lr) For each biennial recertification as an independent review organization under s. 632.835, $100.

SECTION 7. 601.42 (4) of the statutes is amended to read:

601.42 **(4)** REPLIES. Any officer, manager or general agent of any insurer authorized to do or doing an insurance business in this state, any person controlling or having a contract under which the person has a right to control such an insurer, whether exclusively or otherwise, any person with executive authority over or in charge of any segment of such an insurer's affairs, any individual practice association or officer, director or manager of an individual practice association, any insurance agent or other person licensed under chs. 600 to 646, any provider of

services under a continuing care contract, as defined in s. 647.01 (2), any independent review organization certified or recertified under s. 632.835 (4) or any health care provider, as defined in s. 655.001 (8), shall reply promptly in writing or in other designated form, to any written inquiry from the commissioner requesting a reply.

SECTION 8. 609.15 (title) and (1) (intro.) of the statutes are repealed.

SECTION 9. 609.15 (1) (a) of the statutes is renumbered 632.83 (2) (a) and amended to read:

632.83 **(2)** (a) Establish and use an internal grievance procedure that is approved by the commissioner and that complies with sub. ~~(2)~~ (3) for the resolution of ~~enrollees'~~ insureds' grievances with the ~~limited service health organization, preferred provider plan or managed care~~ health benefit plan.

SECTION 10. 609.15 (1) (b) of the statutes is renumbered 632.83 (2) (b) and amended to read:

632.83 **(2)** (b) Provide ~~enrollees~~ insureds with complete and understandable information describing the internal grievance procedure under par. (a).

SECTION 11. 609.15 (1) (c) of the statutes is renumbered 632.83 (2) (c).

SECTION 12. 609.15 (2) (intro.) of the statutes is renumbered 632.83 (3) (intro.) and amended to read:

632.83 **(3)** (intro.) The internal grievance procedure established under sub. ~~(1)~~ (2) (a) shall include all of the following elements:

SECTION 13. 609.15 (2) (a) of the statutes is renumbered 632.83 (3) (a) and amended to read:

632.83 **(3)** (a) The opportunity for an ~~enrollee~~ insured to submit a written grievance in any form.

SECTION 14. 609.15 (2) (b) of the statutes is renumbered 632.83 (3) (b) and amended to read:

632.83 **(3)** (b) Establishment of a grievance panel for the investigation of each grievance submitted under par. (a), consisting of at least one individual authorized to take corrective action on the grievance and at least one ~~enrollee~~ insured other than the grievant, if an ~~enrollee~~ insured is available to serve on the grievance panel.

SECTION 15. 609.15 (2) (c) of the statutes is renumbered 632.83 (3) (c).

SECTION 16. 609.15 (2) (d) of the statutes is renumbered 632.83 (3) (d).

SECTION 17. 609.15 (2) (e) of the statutes is renumbered 632.83 (3) (e).

SECTION 18. 609.655 (4) (b) of the statutes is amended to read:

609.655 **(4)** (b) Upon completion of the review under par. (a), the medical director of the managed care plan shall determine whether the policy or certificate will provide coverage of any further treatment for the dependent student's nervous or mental disorder or alcoholism or other drug abuse problems that is provided by a provider located in reasonably close proximity to the school in which the student is enrolled. If the dependent student disputes the medical director's determination, the dependent student may submit a written grievance under the managed care plan's internal grievance procedure established under s. ~~609.15~~ 632.83.

SECTION 19. 632.83 of the statutes is created to read:

632.83 Internal grievance procedure. (1) In this section, "health benefit plan" has the meaning given in s. 632.745 (11), except that "health benefit plan" includes the coverage specified in s. 632.745 (11) (b) 10. and includes a policy, certificate or contract under s. 632.745 (11) (b) 9. that provides only limited–scope dental or vision benefits.

(2) Every insurer that issues a health benefit plan shall do all of the following:

SECTION 20. 632.835 of the statutes is created to read:

632.835 Independent review of adverse and experimental treatment determinations. (1) DEFINITIONS. In this section:

(a) "Adverse determination" means a determination by or on behalf of an insurer that issues a health benefit plan to which all of the following apply:

1. An admission to a health care facility, the availability of care, the continued stay or other treatment that is a covered benefit has been reviewed.

2. Based on the information provided, the treatment under subd. 1. does not meet the health benefit plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

3. Based on the information provided, the insurer that issued the health benefit plan reduced, denied or terminated the treatment under subd. 1. or payment for the treatment under subd. 1.

4. Subject to sub. (5) (c), the amount of the reduction or the cost or expected cost of the denied or terminated treatment or payment exceeds, or will exceed during the course of the treatment, $500.

(b) "Experimental treatment determination" means a determination by or on behalf of an insurer that issues a health benefit plan to which all of the following apply:

1. A proposed treatment has been reviewed.

2. Based on the information provided, the treatment under subd. 1. is determined to be experimental under the terms of the health benefit plan.

3. Based on the information provided, the insurer that issued the health benefit plan denied the treatment under subd. 1. or payment for the treatment under subd. 1.

4. Subject to sub. (5) (c), the cost or expected cost of the denied treatment or payment exceeds, or will exceed during the course of the treatment, $500.

(c) "Health benefit plan" has the meaning given in s. 632.745 (11), except that "health benefit plan" includes the coverage specified in s. 632.745 (11) (b) 10.

(d) "Treatment" means a medical service, diagnosis, procedure, therapy, drug or device.

(2) REVIEW REQUIREMENTS; WHO MAY CONDUCT. (a) Every insurer that issues a health benefit plan shall establish an independent review procedure whereby an insured under the health benefit plan, or his or her authorized representative, may request and obtain an independent review of an adverse determination or an experimental treatment determination made with respect to the insured.

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

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

(d) An insured is not required to exhaust the internal grievance procedure under s. 632.83 before requesting an independent review if any of the following apply:

1. The insured and the insurer agree that the matter may proceed directly to independent review under sub. (3).

2. Along with the notice to the insurer of the request for independent review under sub. (3) (a), the insured submits to the independent review organization selected by the insured a request to bypass the internal grievance procedure under s. 632.83 and the independent review organization determines that the health condition of the insured is such that requiring the insured to use the internal grievance procedure before proceeding to independent review would jeopardize the life or health of the insured or the insured's ability to regain maximum function.

(3) PROCEDURE. (a) To request an independent review, an insured or his or her authorized representative shall provide timely written notice of the request for independent review, and of the independent review organization selected, to the insurer that made or on whose behalf was made the adverse or experimental treatment determination. The insurer shall immediately notify the commissioner and the independent review organization selected by the insured of the request for independent review. The insured or his or her authorized representative must pay a $50 fee to the independent review organization. If the insured prevails on the review, in whole or in part, the entire amount paid by the insured or his or her authorized representative shall be refunded by the insurer to the insured or his or her authorized representative. For each independent review in which it is involved, an insurer shall pay a fee to the independent review organization.

(b) Within 3 business days after receiving written notice of a request for independent review under par. (a), the insurer shall submit to the independent review organization copies of all of the following:

1. Any information submitted to the insurer by the insured in support of the insured's position in the internal grievance under s. 632.83.

2. The contract provisions or evidence of coverage of the insured's health benefit plan.

3. Any other relevant documents or information used by the insurer in the internal grievance determination under s. 632.83.

(c) Within 5 business days after receiving the information under par. (b), the independent review organization shall request any additional information that it requires for the review from the insured or the insurer. Within 5 business days after receiving a request for additional information, the insured or the insurer shall submit the information or an explanation of why the information is not being submitted.

(d) An independent review under this section may not include appearances by the insured or his or her authorized representative, any person representing the health benefit plan or any witness on behalf of either the insured or the insurer.

(e) In addition to the information under pars. (b) and (c), the independent review organization may accept for consideration any typed or printed, verifiable medical or scientific evidence that the independent review organization determines is relevant, regardless of whether the evidence has been submitted for consideration at any time previously. The insurer and the insured shall submit to the other party to the independent review any information submitted to the independent review organization under this paragraph and pars. (b) and (c). If, on the basis of any

additional information, the insurer reconsiders the insured's grievance and determines that the treatment that was the subject of the grievance should be covered, the independent review is terminated.

(f) If the independent review is not terminated under par. (e), the independent review organization shall, within 30 business days after the expiration of all time limits that apply in the matter, make a decision on the basis of the documents and information submitted under this subsection. The decision shall be in writing, signed on behalf of the independent review organization and served by personal delivery or by mailing a copy to the insured or his or her authorized representative and to the insurer. A decision of an independent review organization is binding on the insured and the insurer.

(g) If the independent review organization determines that the health condition of the insured is such that following the procedure outlined in pars. (b) to (f) would jeopardize the life or health of the insured or the insured's ability to regain maximum function, the procedure outlined in pars. (b) to (f) shall be followed with the following differences:

1. The insurer shall submit the information under par. (b) within one day after receiving the notice of the request for independent review under par. (a).

2. The independent review organization shall request any additional information under par. (c) within 2 business days after receiving the information under par. (b).

3. The insured or insurer shall, within 2 days after receiving a request under par. (c), submit any information requested or an explanation of why the information is not being submitted.

4. The independent review organization shall make its decision under par. (f) within 72 hours after the expiration of the time limits under this paragraph that apply in the matter.

(3m) STANDARDS FOR DECISIONS. (a) A decision of an independent review organization regarding an adverse determination must be consistent with the terms of the health benefit plan under which the adverse determination was made.

(b) A decision of an independent review organization regarding an experimental treatment determination is limited to a determination of whether the proposed treatment is experimental. The independent review organization shall determine that the treatment is not experimental and find in favor of the insured only if the independent review organization finds all of the following:

1. The treatment has been approved by the federal food and drug administration, if the treatment is subject to the approval of the federal food and drug administration.

2. Medically and scientifically accepted evidence clearly demonstrates that the treatment meets all of the following criteria:

a. The treatment is proven safe.

am. The treatment is proven effective for the insured's condition.

b. The treatment can be expected to produce greater benefits than the standard treatment without posing a greater adverse risk to the insured.

c. The treatment meets the coverage terms of the health benefit plan and is not specifically excluded under the terms of the health benefit plan.

(4) CERTIFICATION OF INDEPENDENT REVIEW ORGANIZATIONS. (a) The commissioner shall certify independent review organizations. An independent review organization must demonstrate to the satisfaction of the commissioner that it is

unbiased, as defined by the commissioner by rule. An organization certified under this paragraph must be recertified on a biennial basis to continue to provide independent review services under this section.

(ag) An independent review organization shall have in operation a quality assurance mechanism to ensure the timeliness and quality of the independent reviews, the qualifications and independence of the clinical peer reviewers and the confidentiality of the medical records and review materials.

(ap) An independent review organization shall establish reasonable fees that it will charge for independent reviews and shall submit its fee schedule to the commissioner for a determination of reasonableness and for approval. An independent review organization may not change any fees approved by the commissioner more than once per year and shall submit any proposed fee changes to the commissioner for approval.

(b) An organization applying for certification or recertification as an independent review organization shall pay the applicable fee under s. 601.31 (1) (Lp) or (Lr). Every organization certified or recertified as an independent review organization shall file a report with the commissioner in accordance with rules promulgated under sub. (5) (a) 4.

(c) The commissioner may examine, audit or accept an audit of the books and records of an independent review organization as provided for examination of licensees and permittees under s. 601.43 (1), (3), (4) and (5), to be conducted as provided in s. 601.44, and with costs to be paid as provided in s. 601.45.

(d) The commissioner may revoke, suspend or limit in whole or in part the certification of an independent review organization, or may refuse to recertify an independent review organization, if the commissioner finds that the independent

review organization is unqualified or has violated an insurance statute or rule or a valid order of the commissioner under s. 601.41 (4), or if the independent review organization's methods or practices in the conduct of its business endanger, or its financial resources are inadequate to safeguard, the legitimate interests of consumers and the public. The commissioner may summarily suspend an independent review organization's certification under s. 227.51 (3).

(e) The commissioner shall keep an up–to–date listing of certified independent review organizations and shall provide a copy of the listing to all of the following:

1. Every insurer that is subject to this section, at least quarterly.

2. Any person who requests a copy of the listing.

(5) RULES; REPORT; ADJUSTMENTS. (a) The commissioner shall promulgate rules for the independent review required under this section. The rules shall include at least all of the following:

1. The application procedures for certification and recertification as an independent review organization.

2. The standards that the commissioner will use for certifying and recertifying organizations as independent review organizations, including standards for determining whether an independent review organization is unbiased.

3. Procedures and processes, in addition to those in sub. (3), that independent review organizations must follow.

4. What must be included in the report required under sub. (4) and the frequency with which the report must be filed with the commissioner.

5. Standards for the practices and conduct of independent review organizations.

6. Standards, in addition to those in sub. (6), addressing conflicts of interest by independent review organizations.

(b) The commissioner shall annually submit a report to the legislature under s. 13.172 (2) that specifies the number of independent reviews requested under this section in the preceding year, the insurers and health benefit plans involved in the independent reviews and the dispositions of the independent reviews.

(c) To reflect changes in the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, the commissioner shall at least annually adjust the amounts specified in sub. (1) (a) 4. and (b) 4.

(6) CONFLICT OF INTEREST STANDARDS. (a) An independent review organization may not be affiliated with any of the following:

1. A health benefit plan.

2. A national, state or local trade association of health benefit plans, or an affiliate of any such association.

3. A national, state or local trade association of health care providers, or an affiliate of any such association.

(b) An independent review organization appointed to conduct an independent review and a clinical peer reviewer assigned by an independent review organization to conduct an independent review may not have a material professional, familial or financial interest with any of the following:

1. The insurer that issued the health benefit plan that is the subject of the independent review.

2. Any officer, director or management employe of the insurer that issued the health benefit plan that is the subject of the independent review.

3. The health care provider that recommended or provided the health care service or treatment that is the subject of the independent review, or the health care provider's medical group or independent practice association.

4. The facility at which the health care service or treatment that is the subject of the independent review was or would be provided.

5. The developer or manufacturer of the principal procedure, equipment, drug or device that is the subject of the independent review.

6. The insured or his or her authorized representative.

(6m) QUALIFICATIONS OF CLINICAL PEER REVIEWERS. A clinical peer reviewer who conducts a review on behalf of a certified independent review organization must satisfy all of the following requirements:

(a) Be a health care provider who is expert in treating the medical condition that is the subject of the review and who is knowledgeable about the treatment that is the subject of the review through current, actual clinical experience.

(b) Hold a credential, as defined in s. 440.01 (2) (a), that is not limited or restricted; or hold a license, certificate, registration or permit that authorizes or qualifies the health care provider to perform acts substantially the same as those acts authorized by a credential, as defined in s. 440.01 (2) (a), that was issued by a governmental authority in a jurisdiction outside this state and that is not limited or restricted.

(c) If a physician, hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the review.

(d) Have no history of disciplinary sanctions, including loss of staff privileges, taken or pending by the medical examining board or another regulatory body or by any hospital or government.

(7) IMMUNITY. (a) A certified independent review organization is immune from any civil or criminal liability that may result because of an independent review determination made under this section. An employe, agent or contractor of a certified independent review organization is immune from civil liability and criminal prosecution for any act or omission done in good faith within the scope of his or her powers and duties under this section.

(b) A health benefit plan that is the subject of an independent review and the insurer that issued the health benefit plan shall not be liable in damages to any person for complying with any decision rendered by a certified independent review organization during or at the completion of an independent review.

(8) NOTICE OF SUFFICIENT INDEPENDENT REVIEW ORGANIZATIONS. The commissioner shall make a determination that at least one independent review organization has been certified under sub. (4) that is able to effectively provide the independent reviews required under this section and shall publish a notice in the Wisconsin Administrative Register that states a date that is 2 months after the commissioner makes that determination. The date stated in the notice shall be the date on which the independent review procedure under this section begins operating.

(9) APPLICABILITY. The independent review required under this section shall be available to an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after the first day of the 7th month beginning after the effective date of this subsection .... [revisor inserts date]. Notwithstanding sub. (2) (c), an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after the first day of the 7th month beginning after the effective date of this subsection .... [revisor inserts date], but before the date stated in the notice published by the commissioner in the Wisconsin Administrative Register

under sub. (8) .... [revisor inserts date], must request an independent review no later than 4 months after the date stated in the notice published by the commissioner in the Wisconsin Administrative Register under sub. (8) .... [revisor inserts date].

SECTION 21. Nonstatutory provisions.

(1) RULES REGARDING INDEPENDENT REVIEW. The commissioner of insurance shall submit in proposed form the rules required under section 632.835 (5) (a) of the statutes, as created by this act, to the legislative council staff under section 227.15 (1) of the statutes no later than the first day of the 7th month beginning after the effective date of this paragraph.

SECTION 22. Effective dates. This act takes effect on the day after publication, except as follows:

(1) The treatment of sections 609.15 (title), (1) (intro.), (a), (b) and (c) and (2) (intro.), (a), (b), (c), (d) and (e), 609.655 (4) (b) and 632.83 of the statutes takes effect on the first day of the 7th month beginning after publication.

(2) The treatment of section 632.835 (2), (3), (3m) and (5) (b) and (c) of the statutes takes effect on the date stated in the notice published by the commissioner of insurance in the Wisconsin Administrative Register under section 632.835 (8) of the statutes, as created by this act.

(END)