State of Wisconsin
2011 - 2012 LEGISLATURE

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2011 ASSEMBLY BILL 312

October 7, 2011 – Introduced by Representatives RICHARDS, PASCH, BERCEAU, BERNARD SCHABER, BEWLEY, CLARK, E. COGGS, GRIGSBY, HEBL, HINTZ, MILROY, POCAN, POPE-ROBERTS, ROYS, SEIDEL, SINICKI, C. TAYLOR, TOLES and TURNER, cosponsored by Senators ERPENBACH, C. LARSON, JAUCH, TAYLOR, HOLPERIN, HANSEN, CARPENTER and S. COGGS. Referred to Committee on Insurance.

AN ACT ***to repeal*** 631.95 (3) (a), 632.746 (1) (b), 632.746 (2) (a) and (b), 632.746 (2) (c), (d) and (e), 632.746 (2) (dm), 632.746 (3) (a), 632.746 (3) (d) 2. and 3., 632.746 (10) (a) 4., 632.7497 (3) (b), 632.76 (2) (ac) 2., 632.76 (2) (ac) 3., 632.76 (2) (ac) 4., 632.895 (15) (c) 1. to 4. and 632.895 (15) (c) 6.; ***to renumber*** 632.746 (3) (d) 1. and 632.7497 (3) (a); ***to renumber and amend*** 632.746 (1) (a), 632.76 (2) (ac) 1., 632.895 (13) (a) and 632.895 (15) (a); ***to amend*** 40.51 (8), 40.51 (8), 40.51 (8m), 40.51 (8m), 66.0137 (4), 66.0137 (4), 120.13 (2) (g), 120.13 (2) (g), 185.983 (1) (intro.), 185.983 (1) (intro.), 609.22 (3), 609.845, 625.12 (1) (a) and (e), 625.12 (2), 625.15 (1), 628.34 (3) (a), 631.11 (4) (a) and (b), 631.22 (2), 631.22 (5), 632.746 (5) (a), 632.746 (8) (a) (intro.), 632.746 (10) (a) 1., 632.76 (2) (a), 632.76 (2) (ac) 1., 632.76 (2) (ac) 2., 632.76 (2) (ac) 3. (intro.), 632.76 (2) (b), 632.795 (4) (a), 632.85 (2), 632.883 (2), 632.895 (15) (b), 632.895 (15) (c) 5., 632.897 (11) (a) and 635.02 (2); and ***to create*** 609.845, 632.723, 632.7252, 632.7254, 632.728, 632.746 (2) (dm), 632.7493, 632.753, 632.758, 632.76 (2) (ac)

4., 632.85 (4), 632.865, 632.87 (5m), 632.883, 632.895 (13) (a) 2., 632.895 (13) (a) 3., 632.895 (13) (c), 632.895 (13m), 632.895 (15) (a) 1., 2. and 3., 632.895 (15) (d) and 632.895 (15) (e) of the statutes; **relating to:** implementing federal health insurance law changes.

Analysis by the Legislative Reference Bureau

On March 23, 2010, the federal government enacted the Patient Protection and Affordable Care Act (PPACA), which, among other things, imposes requirements and limitations on health insurance policies and health plans. This bill incorporates some of those requirements and limitations of PPACA into state law.

Under current law, no insurer may rescind an insurance policy for a misrepresentation made by a policyholder if the insurer had constructive or active knowledge of the fact. An insurer may rescind a policy if it acquires knowledge of sufficient facts to constitute grounds for rescission after the policy was issued only if the insurer notifies the insured within 60 days after acquiring the knowledge of its intent to rescind or within 120 days if the insurer needs to gather additional medical information. This bill prohibits an insurer from rescinding a health benefit plan, or a self–insured governmental health plan from recinding a self–insured plan, unless the applicant for coverage committed fraud or made an intentional misrepresentation of material fact with regard to obtaining coverage. The insurer or governmental entity must provide notice before rescinding the plan.

Under current law, a policy or plan providing individual health insurance may not reduce or deny coverage based on a preexisting disease or condition (preexisting condition exclusion) after 12 months after the date of issue of the policy or plan unless the condition was specifically excluded from coverage. The preexisting condition that is excluded from coverage must have been one for which the individual received or was recommended medical advice, diagnosis, care, or treatment within 12 months before the coverage under the plan became effective. A group health benefit plan, under current law may impose a preexisting condition exclusion on an individual's coverage only if the condition being excluded was one for which the individual was recommended or received medical advice, diagnosis, care, or treatment within six months before the individual's enrollment date under the plan. This bill prohibits an insurer under a group health benefit plan or an individual health insurance policy, except for a grandfathered health plan providing individual health coverage, from imposing a preexisting condition exclusion on a participant or beneficiary under the plan who is under 19 years of age. A grandfathered health plan is a health policy or plan in existence on March 23, 2010. As of January 1, 2014, this bill prohibits an insurer that offers a group health benefit plan or an individual health insurance policy, except for a grandfathered health plan providing individual health coverage, from imposing a preexisting condition exclusion on any participant or beneficiary under the plan, regardless of age.

Under the bill, every group health plan, except for a grandfathered health plan, and every insurer providing a health insurance policy, and every self–insured governmental health plan must provide coverage for all preventive care services as defined in PPACA. The bill prohibits a plan or insurer from subjecting the coverage of a preventive care service to a copayment or coinsurance.

This bill requires an individual or group health plan, except a grandfathered health plan, to provide in plain language to the secretary of the federal department of health and human services (DHHS), the commissioner of insurance, any insurance exchange if the plan is sold through an exchange, and the public certain disclosures including claims payment policies and practices, data on enrollment and disenrollment in the plan, and enrollee and participant rights. A health benefit plan, except a grandfathered health plan, is also required to make available upon request on its Internet Web site, and through another means for those without Internet access, a means to permit individuals to learn the amount of cost sharing required under the plan for a specific item or service.

This bill requires that a group or individual health benefit plan, except for a grandfathered health plan, that requires or provides for an individual or beneficiary to designate a primary care provider must allow each individual or beneficiary to designate any participating primary care provider who is available to accept that individual or beneficiary.

Under current law, a health care plan or a self–insured governmental health plan that provides coverage of any emergency medical services must provide coverage of emergency medical services that are provided in a hospital emergency facility and that are needed to evaluate or stabilize an emergency medical condition. Current law prohibits the health care plan or self–insured governmental health plan from requiring prior authorization for those emergency medical services. This bill specifies that the services must be covered regardless whether the hospital emergency facility is a participating provider in the health care plan or self–insured governmental health plan. This bill also requires that the health care plan or self–insured governmental health plan, except for a grandfathered health plan, impose the same cost–sharing requirements on coverage for emergency medical services provided by a nonparticipating provider as it imposes for a participating provider.

With some exceptions, this bill prohibits a self–insured governmental health plan or a health care plan, except for a grandfathered health plan, from restricting benefits for a hospital stay for a mother or newborn to less than 48 hours for a vaginal delivery or less than 96 hours for a cesarean section.

Under current law, every health insurance policy and self–insured governmental health plan that provides coverage of mastectomies must provide coverage of breast reconstruction of the affected tissue incident to a mastectomy. The policy or plan may impose cost–sharing provisions on the breast reconstruction coverage that apply generally under the policy or plan. This bill specifies that all stages of breast reconstruction must be covered by a policy or plan. Under the bill, the policy or plan must also cover surgery and reconstruction of the other breast than the one on which the mastectomy was performed to produce a symmetrical

appearance and prostheses and physical complications of mastectomy. The bill also specifies that all procedures covered must be provided in a manner determined in consultation with the attending physician and the patient. A policy or plan is required under the bill to provide written notice of the available coverage upon enrollment in the policy and annually thereafter.

Under current law, every health insurance policy and every self–insured governmental health plan that provides coverage for a full–time student dependent of the insured, must continue to provide coverage for that dependent if, due to a medically necessary leave of absence, the dependent is no longer a full–time student. The policy or plan is not required to continue coverage unless the medical necessity of the leave of absence is documented and certified by the attending physician. The coverage continues until the dependent advises the policy or plan that he or she no longer intends to return to school full time, becomes employed full time, obtains other health care coverage, marries and is eligible for coverage as a spouse, reaches an age where he or she is no longer eligible for dependent coverage, or has not returned to school full time after one year since the continuation began or until the coverage of the insured under which the dependent has coverage is discontinued or not renewed. This bill specifies that a policy or plan must continue coverage only if the leave commences while the individual is suffering from a serious illness or injury, the leave is medically necessary, and the leave causes the individual to lose student status. The bill specifies that the physician must also document that the dependent is suffering from a serious illness. The bill requires dependent coverage to continue until the coverage would otherwise end or until one year has elapsed since the continuation began and the dependent has not returned to school full time, and the bill eliminates the other situations under which the continued coverage requirement ends. The bill also requires that every policy and plan provide a description of the continued coverage during a medically necessary leave of absence with any notice regarding a requirement for certification of student status for the dependent's coverage. The dependent whose coverage is being continued during a medically necessary leave of absence is entitled under the bill to the same coverage as a full–time student who is not on leave.

Under current law, an insurer is required to provide consumers policies that are coherent, written in commonly understood language, legible, appropriately divided and captioned, and presented in a meaningful sequence. The commissioner of insurance must make rules establishing standards for the understandability of policies and may exempt types of policies from the specific understandability requirements if the commissioner determines that the type of policy is generally understood by those receiving it or those individuals are adequately protected. This bill additionally requires that, no later than March 23, 2012, each health insurer, health plan, and self–insured governmental health plan comply with the standards that the secretary of the federal DHHS will create regarding compiling and providing a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the plan.

This bill requires that no later than March 23, 2012, every health care plan, except for a grandfathered health care plan, and self–insured governmental health

plan must comply with the standards developed by the secretary of the federal DHHS regarding reporting for reimbursement structures to improve health outcomes and other quality measures.

This bill prohibits an insurer or self–insured governmental health plan from imposing a lifetime limit on the dollar value of benefits under the group or individual health care plan or self–insured plan. Before January 1, 2014, an insurer under a group or an individual health care plan, except for a grandfathered health plan providing individual coverage, or a self–insured governmental health plan may impose only a certain annual limit on the dollar value of benefits as defined by the secretary of the federal DHHS. Starting on January 1, 2014, an insurer under a group or individual health care plan, except for a grandfathered health plan providing individual coverage, and a self–insured governmental health plan may not impose an annual limit on the dollar value of benefits.

Under current law, if an insurer provides coverage under a group health benefit plan, the insurer must provide coverage to any eligible employee who becomes an eligible employee after the group coverage commences, and his or her dependents, regardless of health condition or claims experience, with certain exceptions. A self–insured governmental health plan must similarly provide coverage to an eligible employee who waived coverage during an enrollment period, regardless of health condition or claims experience, with certain exceptions. With certain exceptions, under current law, an insurer offering a group health benefit plan must renew coverage at the option of the employer. Current law also requires an insurer that provides an individual health benefit plan to renew the coverage for the insured at the option of the insured, with certain exceptions, but modifications to the individual health benefit plan that comply with the law are allowed. This bill requires any insurer that offers an individual health benefit plan, except for a grandfathered health plan, to offer coverage to any individual, and his or her dependents, that apply for coverage.

Under current law, insurers offering individual or group health insurance policies or plans are not limited in what factors they use to set rates, or premiums, except that they may not discriminate on the basis of race, color, creed, or national origin and they may not under a group health insurance policy or plan charge a higher rate based on a health status–related factor. Rates, under current law, may be modified for individual risks. As of January 1, 2014, health care plans, except for grandfathered health plans, and self–insured governmental health plans, when setting premium rates, may only consider whether the plan covers an individual or a family and the age, tobacco use, and geographic location of any individual covered under the plan. Rates based on age or tobacco use may only vary a certain amount under the bill.

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), 631.95, 632.72 (2), 632.723, 632.7252, 632.7254, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.753, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.865, 632.87 (3) to (6), 632.883, 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 2. 40.51 (8) of the statutes, as affected by 2011 Wisconsin Act .... (this act), 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), 631.95, 632.72 (2), 632.723, 632.7252, 632.7254, 632.728, 632.746 ~~(1)~~ (1m) to (8) and (10), 632.747, 632.748, 632.753, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.865, 632.87 (3) to (6), 632.883, 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 3. 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. 631.95, 632.723, 632.7252, 632.7254, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.753, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.865, 632.87 (5m), 632.883, 632.885, 632.89, and 632.895 (11) to (17).

SECTION 4. 40.51 (8m) of the statutes, as affected by 2011 Wisconsin Act .... (this act), 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. 631.95, 632.723, 632.7252, 632.7254, 632.728, 632.746 ~~(1)~~ (1m) to (8) and (10), 632.747, 632.753, 632.748, 632.798, 632.83,

632.835, 632.85, 632.853, 632.855, 632.865, 632.87 (5m), 632.883, 632.885, 632.89, and 632.895 (11) to (17).

SECTION 5. 66.0137 (4) of the statutes is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self–insured basis, the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.723, 632.7252, 632.7254, 632.746 (2) (dm) and (10) (a) 2. and (b) 2., 632.747 (3), 632.753, 632.798, 632.85, 632.853, 632.855, 632.865, 632.87 (4), ~~(5), and~~ to (6), 632.883, 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 6. 66.0137 (4) of the statutes, as affected by 2011 Wisconsin Act .... (this act), is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self–insured basis, the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.723, 632.7252, 632.7254, 632.728, 632.746 ~~(2) (dm)~~ (1m) and (10) (a) 2. and (b) 2., 632.747 (3), 632.753, 632.798, 632.85, 632.853, 632.855, 632.865, 632.87 (4) to (6), 632.883, 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 7. 120.13 (2) (g) of the statutes is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.723, 632.7252, 632.7254, 632.746 (2) (dm) and (10) (a) 2. and (b) 2., 632.747 (3), 632.753, 632.798, 632.85, 632.853, 632.855, 632.865, 632.87 (4), ~~(5), and~~ to (6), 632.883, 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 8. 120.13 (2) (g) of the statutes, as affected by 2011 Wisconsin Act .... (this act), is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.723, 632.7252, 632.7254, 632.728, 632.746 ~~(2) (dm)~~ (1m) and (10) (a) 2. and (b) 2., 632.747 (3), 632.753, 632.798, 632.85, 632.853, 632.855, 632.865, 632.87 (4) to (6), 632.883, 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 9. 185.983 (1) (intro.) of the statutes is amended to read:

185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a cooperative association organized under s. 185.981 shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.723, 632.7252, 632.7254, 632.745 to 632.749, 632.753, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.865, 632.87 (2)~~,~~ ~~(2m), (3), (4), (5), and~~ to (6), 632.883, 632.885, 632.89, 632.895 (5) and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645, and 646, but the sponsoring association shall:

SECTION 10. 185.983 (1) (intro.) of the statutes, as affected by 2011 Wisconsin Act .... (this act), is amended to read:

185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a cooperative association organized under s. 185.981 shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.723, 632.7252, 632.7254, 632.728, 632.745 to 632.749, 632.753, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.865,

632.87 (2) to (6), 632.883, 632.885, 632.89, 632.895 (5) and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645, and 646, but the sponsoring association shall:

SECTION 11. 609.22 (3) of the statutes is amended to read:

609.22 **(3)** PRIMARY PROVIDER SELECTION. ~~A~~ Except as provided in s. 632.865, a defined network plan that is not a preferred provider plan shall permit each enrollee to select his or her own primary provider from a list of participating primary care physicians and any other participating providers that are authorized by the defined network plan to serve as primary providers. The list shall be updated on an ongoing basis and shall include a sufficient number of primary care physicians and any other participating providers authorized by the plan to serve as primary providers who are accepting new enrollees.

SECTION 12. 609.845 of the statutes is created to read:

609.845 Coverage requirements and limitations; preventive care; maternal and newborn care; quality; standardization. Limited service health organizations, preferred provider plans, and defined network plans are subject to ss. 632.723, 632.7252, 632.7254, 632.746 (2) (dm) or 632.76 (2) (ac) 4., 632.753, 632.865, 632.87 (5m), 632.883, and 632.895 (13m).

SECTION 13. 609.845 of the statutes, as created by 2011 Wisconsin Act .... (this act), is amended to read:

609.845 Coverage requirements and limitations; preventive care; maternal and newborn care; quality; standardization. Limited service health organizations, preferred provider plans, and defined network plans are subject to ss. 632.723, 632.7252, 632.7254, 632.728, 632.746 ~~(2) (dm)~~ (1m) or 632.76 (2) (ac) 4., 632.7493, 632.753, 632.865, 632.87 (5m), 632.883, and 632.895 (13m).

SECTION 14. 625.12 (1) (a) and (e) of the statutes are amended to read:

625.12 **(1)** (a) Past and prospective loss and expense experience within and outside of this state, except as provided in s. 632.728.

(e) Subject to ~~s.~~ ss. 632.365 and 632.728, all other relevant factors, including the judgment of technical personnel.

SECTION 15. 625.12 (2) of the statutes is amended to read:

625.12 **(2)** CLASSIFICATION. ~~Risks~~ Except as provided in s. 632.728, risks may be classified in any reasonable way for the establishment of rates and minimum premiums, except that no classifications may be based on race, color, creed or national origin, and classifications in automobile insurance may not be based on physical condition or developmental disability as defined in s. 51.01 (5). Subject to ~~s.~~ ss. 632.365 and 632.728, rates thus produced may be modified for individual risks in accordance with rating plans or schedules that establish reasonable standards for measuring probable variations in hazards, expenses, or both. Rates may also be modified for individual risks under s. 625.13 (2).

SECTION 16. 625.15 (1) of the statutes is amended to read:

625.15 **(1)** RATE MAKING. ~~An~~ Except as provided in s. 632.728, an insurer may itself establish rates and supplementary rate information for one or more market segments based on the factors in s. 625.12 and, if the rates are for motor vehicle liability insurance, subject to s. 632.365, or the insurer may use rates and supplementary rate information prepared by a rate service organization, with average expense factors determined by the rate service organization or with such modification for its own expense and loss experience as the credibility of that experience allows.

SECTION 17. 628.34 (3) (a) of the statutes is amended to read:

628.34 **(3)** (a) No insurer may unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage except on the basis of classifications related to the nature and the degree of the risk covered or the expenses involved, subject to ss. 632.365, 632.728, 632.746 and 632.748. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket or franchise policy, and terms are not unfairly discriminatory merely because they are more favorable than in a similar individual policy.

SECTION 18. 631.11 (4) (a) and (b) of the statutes are amended to read:

631.11 **(4)** (a) *Knowledge when policy issued.* ~~No~~ Except as provided in s. 632.753, no misrepresentation made by or on behalf of a policyholder and no breach of an affirmative warranty or failure of a condition constitutes grounds for rescission of, or affects an insurer's obligations under, an insurance policy if at the time the policy is issued the insurer has either constructive knowledge of the facts under s. 631.09 (1) or actual knowledge. If the application is in the handwriting of the applicant, the insurer does not have constructive knowledge under s. 631.09 (1) merely because of the agent's knowledge.

(b) *Knowledge acquired after policy issued.* ~~If~~ Except as provided in s. 632.753, after issuance of an insurance policy an insurer acquires knowledge of sufficient facts to constitute grounds for rescission of the policy under this section or a general defense to all claims under the policy, the insurer may not rescind the policy and the defense is not available unless the insurer notifies the insured within 60 days after acquiring such knowledge of its intention to either rescind the policy or defend against a claim if one should arise, or within 120 days if the insurer determines that it is necessary to secure additional medical information.

SECTION 19. 631.22 (2) of the statutes is amended to read:

631.22 **(2)** ~~An~~ Subject to s. 632.7252, an insurer may provide a consumer insurance policy which is delivered to a person obtaining insurance coverage and is not exempt under sub. (5) only if the consumer insurance policy is coherent, written in commonly understood language, legible, appropriately divided and captioned by its various sections and presented in a meaningful sequence. The commissioner shall promulgate rules establishing standards for the determination of compliance with this subsection.

SECTION 20. 631.22 (5) of the statutes is amended to read:

631.22 **(5)** ~~The~~ Except as provided in s. 632.7252, the commissioner may by rule exempt a type of consumer insurance policy from the application of this section if the commissioner finds that type of consumer insurance policy is generally understood by persons to whom it is delivered or that those persons are otherwise adequately protected.

SECTION 21. 631.95 (3) (a) of the statutes is repealed.

SECTION 22. 632.723 of the statutes is created to read:

632.723 Transparency in coverage. (1) REQUIRED INFORMATION. Except as provided in sub. (4), in addition to other required disclosures, a group or individual health benefit plan, as defined in s. 632.745 (11), shall provide the following information to the secretary of the federal department of health and human services and to the commissioner; provide the following information to any insurance exchange, if the plan is sold through an insurance exchange; and make the following information available to the public:

(a) Claims payment policies and practices.

(b) Financial disclosures, periodically.

(c) Data on enrollment in the plan.

(d) Data on disenrollment in the plan.

(e) Data on the number of claims that are denied.

(f) Data on rating practices.

(g) Cost–sharing data and payments with respect to any out–of–network coverage.

(h) Enrollee and participant rights.

(i) Other information required by the secretary of the federal department of health and human services.

(2) LANGUAGE OF DISCLOSURES. (a) In this subsection, "plain language" means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because the language is concise, well–organized, and follows other best practices of plain language writing.

(b) A group or individual health benefit plan, as defined in s. 632.745 (11), shall submit the information required under sub. (1) in plain language.

(3) COST–SHARING TRANSPARENCY. A health benefit plan, as defined in s. 632.745 (11), shall make available on its Internet Web site and through another means for individuals without access to the Internet in a timely manner upon the individual's request a means to permit individuals to learn the amount of cost sharing under the individual's plan or coverage that the individual would be responsible for paying with respect to a specific item or service furnished by a participating provider.

(4) APPLICABILITY. This section does not apply to a grandfathered health plan, as defined in s. 632.758 (1).

SECTION 23. 632.7252 of the statutes is created to read:

632.7252 Uniform explanation of coverage. No later than March 23, 2012, every insurer that offers a health care plan, as defined in s. 628.36 (2) (a) 1., and the

state, and every county, city, village, town, village, and school district that offers a self–insured health plan shall comply with 42 USC 300gg–15 and with the standards developed by the secretary of the federal department of health and human services under 42 USC 300gg–15 for compiling and providing to applicants, enrollees, and policyholders or certificate holders a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the plan.

SECTION 24. 632.7254 of the statutes is created to read:

632.7254 Quality reporting. No later than March 23, 2012, every insurer that offers a health care plan, as defined in s. 628.36 (2) (a) 1., and the state, and every county, city, village, town, village, and school district that offers a self–insured health plan shall comply with 42 USC 300gg–15a and with the standards developed by the secretary of the federal department of health and human services under 42 USC 300gg–15a to require reporting for reimbursement structures that improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, and implement wellness and health promotion activities. This section does not apply to a grandfathered health plan, as defined in s. 632.758 (1).

SECTION 25. 632.728 of the statutes is created to read:

632.728 Rates for individual and group health care plans. (1) In this section:

(a) "Health care plan" has the meaning given in s. 628.36 (2) (a) 1.

(b) "Self–insured health plan" has the meaning given in s. 632.85 (1) (c).

(2) Subject to sub. (3) and except as provided in sub. (4), for the purpose of setting premium rates for coverage under a group or individual health care plan or a self–insured health plan, an insurer, the state, a county, a city, a village, a town, or a school district, may only consider whether the plan covers an individual or a

family and the age, tobacco use, and geographic location of any individual, including any dependent, who is be covered under the plan.

(3) (a) The rate under sub. (2) that is based on age may not vary more than 3 to 1 for adults.

(b) The rate under sub. (2) that is based on tobacco use may not vary more than 1.5 to 1.

(c) The commissioner shall establish one or more geographical rating areas for the purposes of setting premiums or rates under sub. (2).

(4) This section does not apply to a grandfathered health plan, as defined in s. 632.758 (1).

SECTION 26. 632.746 (1) (a) of the statutes is renumbered 632.746 (1m) and amended to read:

632.746 **(1m)** ~~Subject to subs. (2) and (3), an~~ An insurer that offers a group health benefit plan may~~, with respect to a participant or beneficiary under the plan,~~ not impose a preexisting condition exclusion ~~only if the exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6–month period ending on the participant's or beneficiary's enrollment date under the plan~~ on a participant or beneficiary under the plan.

SECTION 27. 632.746 (1) (b) of the statutes is repealed.

SECTION 28. 632.746 (2) (a) and (b) of the statutes are repealed.

SECTION 29. 632.746 (2) (c), (d) and (e) of the statutes are repealed.

SECTION 30. 632.746 (2) (dm) of the statutes is created to read:

632.746 **(2)** (dm) An insurer offering a group health benefit plan may not impose a preexisting condition exclusion or otherwise discriminate against an

individual who is under 19 years of age and who is a participant or beneficiary under the plan.

SECTION 31. 632.746 (2) (dm) of the statutes, as created by 2011 Wisconsin Act .... (this act), is repealed.

SECTION 32. 632.746 (3) (a) of the statutes is repealed.

SECTION 33. 632.746 (3) (d) 1. of the statutes is renumbered 632.746 (3) (d).

SECTION 34. 632.746 (3) (d) 2. and 3. of the statutes are repealed.

SECTION 35. 632.746 (5) (a) of the statutes is amended to read:

632.746 **(5)** (a) If an insurer ~~that made an election under sub. (3) (d) 2.~~ enrolls an individual for coverage under a group health benefit plan and the individual provides a certification under sub. (4), upon the request of that insurer or the group health benefit plan the insurer that issued the certification shall promptly disclose to the requesting insurer or group health benefit plan information on coverage of classes or categories of health benefits available under the coverage on which the certification was based.

SECTION 36. 632.746 (8) (a) (intro.) of the statutes is amended to read:

632.746 **(8)** (a) (intro.) A health maintenance organization that offers a group health benefit plan ~~and that does not impose any preexisting condition exclusion under sub. (1)~~ with respect to a particular coverage option may impose an affiliation period for that coverage option, but only if all of the following apply:

SECTION 37. 632.746 (10) (a) 1. of the statutes is amended to read:

632.746 **(10)** (a) 1. Except as provided in rules promulgated under subd. 3. ~~or 4.~~, if an insurer offers a group health benefit plan to an employer, the insurer shall offer coverage to all of the eligible employees of the employer and their dependents. Except as provided in rules promulgated under subd. 3. ~~or 4.~~, an insurer may not offer

coverage to only certain individuals in an employer group or to only part of the group, except for an eligible employee who has not yet satisfied an applicable waiting period, if any.

SECTION 38. 632.746 (10) (a) 4. of the statutes is repealed.

SECTION 39. 632.7493 of the statutes is created to read:

632.7493 Guaranteed issue for individual health benefit plans. If an insurer offers an individual health benefit plan, the insurer shall offer coverage to an individual who applies for an individual health benefit plan and shall offer coverage to any dependents of that individual. This section does not apply to a grandfathered health plan, as defined in s. 632.758 (1).

SECTION 40. 632.7497 (3) (a) of the statutes is renumbered 632.7497 (3).

SECTION 41. 632.7497 (3) (b) of the statutes is repealed.

SECTION 42. 632.753 of the statutes is created to read:

632.753 Rescission prohibited. An insurer may not rescind a health benefit plan, as defined in 632.745 (11) (a), and the state or a county, city, village, town, or school district may not rescind a self–insured health plan, except if the applicant for the policy or plan committed fraud or made an intentional misrepresentation of material fact with regard to obtaining coverage under policy. The insurer or the state or a county, city, village, town, or school district shall provide notice to the enrollee before a rescission under this section.

SECTION 43. 632.758 of the statutes is created to read:

632.758 Special treatment of grandfathered health plans. (1) DEFINITION. In this section, "grandfathered health plan" means any group health plan or group or individual health insurance coverage in which an individual was enrolled on March 23, 2010.

(2) PREEXISTING CONDITION EXCLUSION. (a) No claim or loss incurred or disability commencing after 12 months from the date of issue of a grandfathered health plan that provides individual health insurance coverage may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of the loss.

(b) A grandfathered health plan that provides individual health insurance coverage may not define a preexisting condition more restrictively than a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within 12 months before the effective date of coverage.

SECTION 44. 632.76 (2) (a) of the statutes is amended to read:

632.76 **(2)** (a) No claim for loss incurred or disability commencing after 2 years from the date of issue of the policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of loss. This paragraph does not apply to a group health benefit plan, as defined in s. 632.745 (9), which is subject to s. 632.746, a disability insurance policy, as defined in s. 632.895 (1) (a), or a self–insured health plan, as defined in s. 632.745 (24).

SECTION 45. 632.76 (2) (ac) 1. of the statutes is amended to read:

632.76 **(2)** (ac) 1. Notwithstanding par. (a) and except as provided in subd. 4., no claim or loss incurred or disability commencing after 12 months from the date of issue of an individual disability insurance policy, as defined in s. 632.895 (1) (a), may be reduced or denied on the ground that a disease or physical condition existed prior

to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of the loss.

SECTION 46. 632.76 (2) (ac) 1. of the statutes, as affected by 2011 Wisconsin Act .... (this act), is renumbered 632.76 (2) (am) and amended to read:

632.76 **(2)** (am) Notwithstanding par. (a) ~~and except as provided in subd. 4.~~, no claim or loss incurred ~~or disability commencing after 12 months from the date of issue of~~ under an individual disability insurance policy, as defined in s. 632.895 (1) (a), may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage~~, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of the loss~~. This paragraph does not apply to a grandfathered health plan, as defined in s. 632.758 (1), that provides individual health insurance coverage.

SECTION 47. 632.76 (2) (ac) 2. of the statutes is amended to read:

632.76 **(2)** (ac) 2. Except as provided in ~~subd.~~ subds. 3. and 4., an individual disability insurance policy, as defined in s. 632.895 (1) (a), other than a short–term policy subject to s. 632.7495 (4) and (5), may not define a preexisting condition more restrictively than a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within 12 months before the effective date of coverage.

SECTION 48. 632.76 (2) (ac) 2. of the statutes, as affected by 2011 Wisconsin Act .... (this act), is repealed.

SECTION 49. 632.76 (2) (ac) 3. (intro.) of the statutes is amended to read:

632.76 **(2)** (ac) 3. (intro.) Except as provided in subd. 4. and except as the commissioner provides by rule under s. 632.7495 (5), all of the following apply to an

individual disability insurance policy that is a short–term policy subject to s. 632.7495 (4) and (5):

SECTION 50. 632.76 (2) (ac) 3. of the statutes, as affected by 2011 Wisconsin Act .... (this act), is repealed.

SECTION 51. 632.76 (2) (ac) 4. of the statutes is created to read:

632.76 **(2)** (ac) 4. No individual disability insurance policy, as defined in s. 632.895 (1) (a), or self–insured health plan, as defined in 632.745 (24), may reduce or deny a claim for loss by a participant or beneficiary under the policy or plan who is under the age of 19 on the ground that a disease or physical condition existed prior to the effective date of coverage. This subdivision does not apply to a grandfathered health plan, as defined in s. 632.758 (1), that provides individual health insurance coverage.

SECTION 52. 632.76 (2) (ac) 4. of the statutes, as affected by 2011 Wisconsin Act .... (this act), is repealed.

SECTION 53. 632.76 (2) (b) of the statutes is amended to read:

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

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

SECTION 54. 632.795 (4) (a) of the statutes is amended to read:

632.795 **(4)** (a) An insurer subject to sub. (2) shall provide coverage under the same policy form and for the same premium as it originally offered in the most recent enrollment period, subject only to the medical underwriting used in that enrollment period. Unless otherwise prescribed by rule, the insurer may apply deductibles, ~~preexisting condition limitations,~~ waiting periods, or other limits only to the extent that they would have been applicable had coverage been extended at the time of the most recent enrollment period and with credit for the satisfaction or partial satisfaction of similar provisions under the liquidated insurer's policy or plan. The insurer may exclude coverage of claims that are payable by a solvent insurer under insolvency coverage required by the commissioner or by the insurance regulator of another jurisdiction. Coverage shall be effective on the date that the liquidated insurer's coverage terminates.

SECTION 55. 632.85 (2) of the statutes is amended to read:

632.85 **(2)** If a health care plan or a self–insured health plan provides coverage of any emergency medical services, the health care plan or self–insured health plan shall provide coverage of emergency medical services that are provided in a hospital

emergency facility, regardless whether that facility is a participating provider with respect to the plan, and that are needed to evaluate or stabilize, as defined in section 1867 of the federal Social Security Act, an emergency medical condition.

SECTION 56. 632.85 (4) of the statutes is created to read:

632.85 **(4)** A health care plan or self–insured health plan that is required to provide the coverage under sub. (2) shall impose the same cost–sharing requirements on coverage for emergency medical services provided by a nonparticipating provider as it imposes for services provided by a participating provider. This subsection does not apply to a grandfathered health plan, as defined in s. 632.758 (1).

SECTION 57. 632.865 of the statutes is created to read:

632.865 Choice of primary care provider. A group or individual health benefit plan, as defined in s. 632.745 (11), that requires or provides for the designation by any individual or beneficiary covered under the plan of a participating primary care provider shall allow each individual or beneficiary to designate any participating primary care provider who is available to accept that individual or beneficiary. This section does not apply to a grandfathered health plan, as defined in s. 632.758 (1).

SECTION 58. 632.87 (5m) of the statutes is created to read:

632.87 **(5m)** (a) 1. Except as provided in subd. 2. and par. (d), no health care plan, as defined in s. 628.36 (2) (a) 1., that provides coverage for hospital lengths of stay in connection with childbirth for a mother or a newborn child may do any of the following:

a. Restrict benefits under the plan for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours.

b. Restrict benefits under the plan for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours.

c. Require that a provider obtain authorization from the plan for prescribing any length of stay required under subd. 1. a. or b.

2. Subdivision 1. does not apply to a health care plan in any case in which the decision to discharge the mother or her newborn child before the minimum length of stay described under subd. 1. a. or b. is made by an attending provider in consultation with the mother.

(b) No health care plan, as defined in s. 628.36 (2) (a) 1., may do any of the following:

1. Deny to the mother or her newborn child eligibility, or continued eligibility, to enroll in or renew coverage under the plan solely for the purpose of avoiding the requirements of this subsection.

2. Provide monetary payments or rebates to mothers to encourage mothers to accept less than the minimum protections available under this subsection.

3. Penalize a provider or reduce or limit the reimbursement of a provider because the provider provided care to an individual in accordance with this subsection.

4. Subject to par. (c), restrict benefits for any portion of a hospital length of stay under subd. 1. a. or b. in a manner that is less favorable than the benefits provided for any preceding portion of the stay.

(c) A health care plan may impose cost–sharing requirements in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child, except that those cost–sharing requirements for any portion of a hospital length of stay may not be greater than the cost–sharing requirements for any preceding portion of the stay.

(d) This subsection does not apply to a grandfathered health plan, as defined in s. 632.758 (1).

SECTION 59. 632.883 of the statutes is created to read:

632.883 Lifetime and annual limits. (1) No insurer may impose a lifetime limit on the dollar value of benefits under a group or individual health care plan, as defined in s. 628.36 (2) (a) 1., and no self–insured health plan, as defined in s. 632.745 (24), may impose a lifetime limit on the dollar value of benefits under the self–insured health plan.

(2) For plan years beginning before January 1, 2014, an insurer under a group or individual health care plan, as defined in s. 628.36 (2) (a) 1., and a self–insured health plan, as defined in s. 632.745 (24), may impose only a restricted annual limit on the dollar value of benefits, as restricted annual limit is defined by the secretary of the federal department of health and human services under 42 USC 300gg–11 (a). This subsection does not apply to a grandfathered health plan, as defined in s. 632.758 (1), that provides individual health insurance coverage.

SECTION 60. 632.883 (2) of the statutes, as created by 2011 Wisconsin Act .... (this act), is amended to read:

632.883 **(2)** ~~For plan years beginning before January 1, 2014, an~~ No insurer under a group or individual health care plan, as defined in s. 628.36 (2) (a) 1., and ~~a~~ no self–insured health plan, as defined in s. 632.745 (24), may impose ~~only a~~

~~restricted~~ an annual limit on the dollar value of benefits~~, as restricted annual limit is defined by the secretary of the federal department of health and human services under 42 USC 300gg–11 (a)~~. This subsection does not apply to a grandfathered health plan, as defined in s. 632.758 (1), that provides individual health insurance coverage.

SECTION 61. 632.895 (13) (a) of the statutes is renumbered 632.895 (13) (a) (intro.) and amended to read:

632.895 **(13)** (a) (intro.) Every disability insurance policy, and every self–insured health plan of the state or a county, city, village, town or school district, that provides coverage of the surgical procedure known as a mastectomy shall provide coverage of all of the following in a manner determined in consultation with the attending physician and the patient:

1. All stages of breast reconstruction of the affected tissue incident to a mastectomy.

SECTION 62. 632.895 (13) (a) 2. of the statutes is created to read:

632.895 **(13)** (a) 2. Surgery and reconstruction of the other breast than the one on which the mastectomy was performed to produce a symmetrical appearance.

SECTION 63. 632.895 (13) (a) 3. of the statutes is created to read:

632.895 **(13)** (a) 3. Prostheses and physical complications of mastectomy, including lymphademas.

SECTION 64. 632.895 (13) (c) of the statutes is created to read:

632.895 **(13)** (c) The disability insurance policy and self–insured health plan shall provide written notice of the available coverage under par. (a) upon enrollment in the policy or plan and annually thereafter.

SECTION 65. 632.895 (13m) of the statutes is created to read:

632.895 **(13m)** PREVENTIVE CARE COPAYMENTS PROHIBITED. (a) In this subsection, "preventive care service" means any service described under 42 USC 300gg–13 (a).

(b) Except as provided in par. (d), every group health plan, every insurer providing a disability insurance policy, and every self–insured health plan of the state or a county, city, town, village, or school district, shall provide coverage for all preventive care services.

(c) No insurer or plan described under par. (b) may subject the coverage of a preventive care service to a copayment or coinsurance.

(d) This subsection does not apply to a grandfathered health plan, as defined in s. 632.758 (1).

SECTION 66. 632.895 (15) (a) of the statutes is renumbered 632.895 (15) (a) (intro.) and amended to read:

632.895 **(15)** (a) (intro.) Subject to pars. (b) and (c), every disability insurance policy, and every self–insured health plan of the state or a county, city, town, village, or school district, that provides coverage for a person as a dependent of the insured because the person is a full–time student, including the coverage under s. 632.885 (2) (b), shall continue to provide dependent coverage for the person if, due to a ~~medically necessary~~ leave of absence, he or she ceases to be a full–time student~~.~~, if the leave of absence meets all of the following criteria:

SECTION 67. 632.895 (15) (a) 1., 2. and 3. of the statutes are created to read:

632.895 **(15)** (a) 1. The leave of absence commences while the person is suffering from a serious illness or injury.

2. The leave of absence is medically necessary.

3. The leave of absence causes the person to lose student status for purposes of coverage under the terms of the plan or coverage.

SECTION 68. 632.895 (15) (b) of the statutes is amended to read:

632.895 **(15)** (b) A policy or plan is not required to continue coverage under par. (a) unless the person submits documentation and written certification ~~of the medical necessity of~~ by a treating physician that states the person is suffering from a serious illness or injury and that the leave of absence ~~from the person's attending physician~~ is medically necessary. The date on which the person ceases to be a full–time student due to the medically necessary leave of absence shall be the date on which the coverage continuation under par. (a) begins.

SECTION 69. 632.895 (15) (c) 1. to 4. of the statutes are repealed.

SECTION 70. 632.895 (15) (c) 5. of the statutes is amended to read:

632.895 **(15)** (c) 5. Except for a person who has coverage as a dependent under s. 632.885 (2) (b), the ~~person reaches the age at which~~ coverage ~~as a dependent who is a full–time student~~ would otherwise end under the terms and conditions of the policy or plan.

SECTION 71. 632.895 (15) (c) 6. of the statutes is repealed.

SECTION 72. 632.895 (15) (d) of the statutes is created to read:

632.895 **(15)** (d) Every disability insurance policy and every self–insured health plan that provides coverage under par. (a) shall include with any notice regarding a requirement for certification of student status for coverage under the plan or coverage a description of the terms of this subsection for continued coverage during a medically necessary leave of absence. The policy or plan shall provide the description in language that is understandable to the typical insured or plan participant.

SECTION 73. 632.895 (15) (e) of the statutes is created to read:

632.895 **(15)** (e) A person whose benefits are continued under par. (a) is entitled to the same benefits as if, during the medically necessary leave of absence, the person continued to be covered under the policy or plan as a full–time student who is not on a leave of absence.

SECTION 74. 632.897 (11) (a) of the statutes is amended to read:

632.897 **(11)** (a) Notwithstanding subs. (2) to (10), the commissioner may promulgate rules establishing standards requiring insurers to provide continuation of coverage for any individual covered at any time under a group policy who is a terminated insured or an eligible individual under any federal program that provides for a federal premium subsidy for individuals covered under continuation of coverage under a group policy, including rules governing election or extension of election periods, notice, rates, premiums, premium payment, ~~application of preexisting condition exclusions,~~ election of alternative coverage, and status as an eligible individual, as defined in s. 149.10 (2t).

SECTION 75. 635.02 (2) of the statutes is amended to read:

635.02 **(2)** "Case characteristics" means the demographic, actuarially based ~~characteristics~~ ages, geographic locations, and tobacco usage of the employees of a small employer, and the employer, if covered, ~~such as age, sex, and geographic location,~~ used by a small employer insurer to determine premium rates for a small employer. "Case characteristics" does not include loss or claim history, health status, occupation, duration of coverage, or other factors related to claim experience.

SECTION 76. Initial applicability.

(1) The treatment of sections 40.51 (8) (by SECTION 1) and (8m) (by SECTION 3), 66.0137 (4) (by SECTION 5), 120.13 (2) (g) (by SECTION 7), 185.983 (1) (intro.) (by SECTION 9), 632.758, 632.85 (2), and 632.895 (15) (b), (c) 5., (d), and (e) of the statutes,

the renumbering and amendment of section 632.895 (13) (a) and (15) (a) of the statutes, and the creation of sections 609.845, 632.723, 632.746 (2) (dm), 632.753, 632.76 (2) (ac) 4., 632.85 (4), 632.865, 632.87 (5m), 632.883, and 632.895 (13) (a) 2. and 3. and (c), (13m), and (15) (a) 1., 2., and 3., (d), and (e) of the statutes first apply to policies or plans that are newly issued or renewed, or self–insured governmental or school district health plans that are established, extended, modified, or renewed, on the effective date of this subsection.

(2) The treatment of sections 40.51 (8) (by SECTION 2) and (8m) (by SECTION 4), 66.0137 (4) (by SECTION 6), 120.13 (2) (g) (by SECTION 8), 185.983 (1) (intro.) (by SECTION 10), 609.845 (by SECTION 13), 625.12 (1) (a) and (e) and (2), 625.15 (1), 628.34 (3) (a), 632.746 (8) (a) (intro.) and (10) (a) 1., 632.795 (4) (a), 632.883 (2) (by SECTION 60), 632.897 (11) (a), and 635.02 (2) of the statutes, the renumbering of section 632.7497 (3) (a) of the statutes, the renumbering and amendment of sections 632.746 (1) (a) and 632.76 (2) (ac) 1. of the statutes, and the creation of sections 632.728 and 632.7493 of the statutes first apply to policies or plans that are newly issued or renewed, or self–insured governmental or school district health plans that are established, extended, modified, or renewed, on the effective date of this subsection.

SECTION 77. Effective dates. This act takes effect on the day after publication, except as follows:

(1) The treatment of sections 40.51 (8) (by SECTION 2) and (8m) (by SECTION 4), 66.0137 (4) (by SECTION 6), 120.13 (2) (g) (by SECTION 8), 185.983 (1) (intro.) (by SECTION 10), 609.845 (by SECTION 13), 625.12 (1) (a) and (e) and (2), 625.15 (1), 628.34 (3) (a), 632.746 (5) (a), (8) (a) (intro.), and (10) (a) 1., 632.76 (2) (b), 632.795 (4) (a), 632.883 (2) (by SECTION 60), 632.897 (11) (a), and 635.02 (2) of the statutes, the repeal of sections 631.95 (3) (a), 632.746 (1) (b), (2) (a), (b), and (dm), (3) (a) and (d) 2. and

3., and (10) (a) 4., 632.7497 (3) (b), and 632.76 (2) (ac) 2., 3., and 4. of the statutes, the renumbering of sections 632.746 (3) (d) 1. and 632.7497 (3) (a) of the statutes, the renumbering and amendment of sections 632.746 (1) (a) and 632.76 (2) (ac) 1. of the statutes, and the creation of sections 632.728 and 632.7493 of the statutes, and SECTION 76 (2) of this act take effect on January 1, 2014.

(END)