

1999 ASSEMBLY BILL 518

October 5, 1999 – Introduced by Representatives UNDERHEIM, F. LASEE, MUSSER, KELSO, URBAN, LADWIG, ALBERS, KAUFERT and KEDZIE, cosponsored by Senators BRESKE, ROSENZWEIG, ROESSLER, DARLING, SCHULTZ and DRZEWIECKI. Referred to Committee on Insurance.

1 **AN ACT** *to renumber* 609.15 (1) (c), 609.15 (2) (c), 609.15 (2) (d) and 609.15 (2)
 2 (e); *to renumber and amend* 609.15 (1) (intro.), 609.15 (1) (a), 609.15 (1) (b),
 3 609.15 (2) (intro.), 609.15 (2) (a) and 609.15 (2) (b); *to amend* 40.51 (8), 40.51
 4 (8m), 600.01 (2) (b) and 601.42 (4); and *to create* 111.91 (2) (r), 601.31 (1) (Lp),
 5 601.31 (1) (Lr), 632.83 and 632.835 of the statutes; **relating to:** requiring all
 6 insurers to establish internal grievance procedures, independent review of
 7 certain coverage determinations made by health benefit plans, granting
 8 rule-making authority and providing an exemption from emergency rule
 9 procedures.

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 health benefit plan to have such an internal grievance procedure. In addition, the bill requires every health benefit plan, including managed care plans and plans covering state and municipal employees, to have an independent review procedure for review of certain decisions under the

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health benefit plan's internal grievance procedure that are adverse to insureds. The decision must relate to the plan's denial of treatment or payment for treatment that the plan determined was experimental or to the plan'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 value 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 the 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 actual clinical experience in treating the condition that is the subject of the review. Every insurer that issues a health benefit plan must contract with one or more certified independent review organizations for the purpose of conducting the independent reviews in which the plan is involved. A contract must be at least two years long, and an insurer must inform the commissioner if such a contract is not renewed and of the reasons for the nonrenewal.

To request an independent review, an insured must provide written notice of the request to the health benefit plan, which must inform the commissioner of the request and inform the insured of the name and address of the independent review organization that will be conducting the independent review. The insured must pay \$50 to the independent review organization, which is refunded to the insured if he or she prevails, in whole or in part, in the independent review. In addition, the plan must pay a fee to the independent review organization for each review.

Within three days after receiving the notice from the insured, the health benefit plan 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

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required because of the enrollee'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 health benefit plan must be covered. The decision at the conclusion of an independent review, which is binding on the insured and the health benefit plan, 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.

Finally, the bill requires the commissioner to determine when a sufficient number of independent review organizations have been certified 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 six 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:

1 **SECTION 1.** 40.51 (8) of the statutes is amended to read:

2 40.51 **(8)** Every health care coverage plan offered by the state under sub. (6)
3 shall comply with ss. 631.89, 631.90, 631.93 (2), 632.72 (2), 632.746 (1) to (8) and (10),
4 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (5),
5 632.895 (5m) and (8) to (13) and 632.896.

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

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1 40.51 **(8m)** Every health care coverage plan offered by the group insurance
2 board under sub. (7) shall comply with ss. 632.746 (1) to (8) and (10), 632.747,
3 632.748, 632.83, 632.835, 632.85, 632.853, 632.855 and 632.895 (11) to (13).

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

5 111.91 **(2)** (r) The requirements related to internal grievance procedures under
6 s. 632.83 and independent review of certain health benefit plan determinations
7 under s. 632.835.

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

9 600.01 **(2)** (b) Group or blanket insurance described in sub. (1) (b) 3. and 4. is
10 not exempt from ss. 632.745 to 632.749, 632.83 or 632.835 or ch. 633 or 635.

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

12 601.31 **(1)** (Lp) For certifying as an independent review organization under s.
13 632.835, \$400.

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

15 601.31 **(1)** (Lr) For each biennial recertification as an independent review
16 organization under s. 632.835, \$100.

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

18 601.42 **(4)** REPLIES. Any officer, manager or general agent of any insurer
19 authorized to do or doing an insurance business in this state, any person controlling
20 or having a contract under which the person has a right to control such an insurer,
21 whether exclusively or otherwise, any person with executive authority over or in
22 charge of any segment of such an insurer's affairs, any individual practice
23 association or officer, director or manager of an individual practice association, any
24 insurance agent or other person licensed under chs. 600 to 646, any provider of
25 services under a continuing care contract, as defined in s. 647.01 (2), any

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

4 **SECTION 8.** 609.15 (1) (intro.) of the statutes is renumbered 609.15 and
5 amended to read:

6 **609.15 Grievance procedure.** Each limited service health organization,
7 preferred provider plan and managed care plan shall ~~do all of the following:~~ establish
8 and use an internal grievance procedure as provided in s. 632.83.

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

11 632.83 (2) (a) Establish and use an internal grievance procedure that is
12 approved by the commissioner and that complies with sub. ~~(2)~~ (3) for the resolution
13 of enrollees' insureds' grievances with the ~~limited service health organization,~~
14 ~~preferred provider plan or managed care~~ health benefit plan.

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

17 632.83 (2) (b) Provide ~~enrollees~~ insureds with complete and understandable
18 information describing the internal grievance procedure under par. (a).

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

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

22 632.83 (3) (intro.) The internal grievance procedure established under sub. ~~(1)~~
23 ~~(2)~~ (a) shall include all of the following elements:

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

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1 632.83 (3) (a) The opportunity for an enrollee insured to submit a written
2 grievance in any form.

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

5 632.83 (3) (b) Establishment of a grievance panel for the investigation of each
6 grievance submitted under par. (a), consisting of at least one individual authorized
7 to take corrective action on the grievance and at least one ~~enrollee~~ insured other than
8 the grievant, if an ~~enrollee~~ insured is available to serve on the grievance panel.

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

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

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

12 **SECTION 18.** 632.83 of the statutes is created to read:

13 **632.83 Internal grievance procedure. (1)** In this section, “health benefit
14 plan” has the meaning given in s. 632.745 (11), except that “health benefit plan”
15 includes the coverage specified in s. 632.745 (11) (b) 10.

16 **(2)** Each health benefit plan shall do all of the following:

17 **SECTION 19.** 632.835 of the statutes is created to read:

18 **632.835 Independent review of adverse and experimental treatment**
19 **determinations. (1) DEFINITIONS.** In this section:

20 (a) “Adverse determination” means a determination by or on behalf of a health
21 benefit plan to which all of the following apply:

22 1. An admission to a health care facility, the availability of care, the continued
23 stay or another health care service that is a covered benefit has been reviewed.

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

4 3. Based on the information provided, the health benefit plan reduced, denied
5 or terminated the health care service under subd. 1. or payment for the health care
6 service under subd. 1.

7 4. Subject to sub. (5) (c), the amount of the reduction or the value of the denied
8 or terminated service or payment exceeds \$500, excluding deductibles and
9 copayments.

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

12 1. A proposed treatment has been reviewed.

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

15 3. Based on the information provided, the health benefit plan denied the
16 treatment under subd. 1. or payment for the treatment under subd. 1.

17 4. Subject to sub. (5) (c), the value of the denied treatment or payment exceeds
18 \$500, excluding deductibles and copayments.

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

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

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1 (b) An independent review under this section may be conducted only by an
2 independent review organization certified under sub. (4). Every insurer issuing a
3 health benefit plan shall contract with one or more independent review
4 organizations certified under sub. (4) for the purpose of conducting independent
5 reviews of adverse determinations and experimental treatment determinations
6 made by or on behalf of the health benefit plan. The term of a contract with an
7 independent review organization may not be less than 2 years. If an insurer fails to
8 renew the contract of an independent review organization at the end of the contract
9 term, the insurer shall inform the commissioner that the contract has not been
10 renewed and of the reasons for the nonrenewal.

11 (c) An insured must exhaust the health benefit plan's internal grievance
12 procedure before the insured may request an independent review under this section,
13 unless the delay will result for the insured in serious injury or impairment or a
14 life-threatening condition, as determined by the insured's treating health care
15 provider. Except as provided in sub. (9), an insured must request an independent
16 review as provided in sub. (3) (a) within 4 months after the insured receives notice
17 of the disposition of his or her grievance under s. 632.83 (3) (d).

18 (d) Whenever an adverse determination or an experimental treatment
19 determination is made, the health benefit plan involved in the determination shall
20 advise the insured of the insured's right to obtain the independent review required
21 under this section, how to request the review and the time within which the review
22 must be requested.

23 **(3) PROCEDURE.** (a) To request an independent review, an insured or his or her
24 authorized representative shall provide timely written notice of the request for
25 independent review to the health benefit plan that made or on whose behalf was

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1 made the adverse or experimental treatment determination. The health benefit plan
2 shall immediately notify the commissioner of the request for independent review and
3 notify the insured of the name and address of the independent review organization
4 that will be conducting the review. The insured or his or her authorized
5 representative must pay a \$50 fee to the independent review organization. If the
6 insured prevails on the review, in whole or in part, the entire amount paid by the
7 insured or his or her authorized representative shall be refunded by the health
8 benefit plan to the insured or his or her authorized representative. For each
9 independent review in which it is involved, a health benefit plan shall pay a fee to
10 the independent review organization.

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

14 1. Any information submitted to the health benefit plan by the insured in
15 support of the insured's position in the internal grievance under s. 632.83.

16 2. The contract provisions or evidence of coverage of the health benefit plan.

17 3. Any other relevant documents or information used by the health benefit plan
18 in the internal grievance determination under s. 632.83.

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

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1 (d) In addition to the information under pars. (b) and (c), the independent
2 review organization may accept for consideration any typed or printed, verifiable
3 medical or scientific evidence that the independent review organization determines
4 is relevant, regardless of whether the evidence has been submitted for consideration
5 at any time previously. The health benefit plan and the insured shall submit to the
6 other party to the independent review any information submitted to the independent
7 review organization under pars. (b) to (d).

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

12 (f) The independent review organization shall, within 30 business days after
13 the expiration of all time limits that apply in the matter, make a decision on the basis
14 of the documents and information submitted under this subsection. The decision
15 shall be in writing, signed on behalf of the independent review organization and
16 served by personal delivery or by mailing a copy to the insured or his or her
17 authorized representative and to the health benefit plan. A decision of an
18 independent review organization is binding on the insured and the health benefit
19 plan.

20 (g) If, in the judgment of the insured's treating health care provider, the adverse
21 or experimental treatment determination relates to a serious injury or impairment
22 or a life-threatening condition, the procedure outlined in pars. (b) to (f) shall be
23 followed with the following differences:

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

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

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

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

13 **(3m)** STANDARDS FOR DECISIONS. (a) A decision of an independent review
14 organization regarding an adverse determination must be consistent with the terms
15 of the health benefit plan under which the adverse determination was made.

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

21 1. The insured has a terminal condition, or the insured's ability to regain or
22 maintain maximum function would be impaired by withholding the proposed
23 treatment.

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1 2. The insured has a condition for which standard treatment would not be
2 medically indicated for the insured or for which there is no standard treatment
3 available that would be as beneficial for the insured as the proposed treatment.

4 3. Scientifically valid studies using accepted protocols and published in peer
5 reviewed literature demonstrate that the proposed treatment is likely to be more
6 beneficial for the insured than available standard treatment.

7 4. The proposed treatment is not specifically excluded under the terms of the
8 health benefit plan and would be covered except for the determination that the
9 treatment is experimental for the insured's condition.

10 **(4) CERTIFICATION OF INDEPENDENT REVIEW ORGANIZATIONS.** (a) The commissioner
11 shall certify independent review organizations. An independent review
12 organization must demonstrate to the satisfaction of the commissioner that it is
13 unbiased, as defined by the commissioner by rule. An organization certified under
14 this paragraph must be recertified on a biennial basis to continue to provide
15 independent review services under this section.

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

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

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1 (d) The commissioner may revoke, suspend or limit in whole or in part the
2 certification of an independent review organization, or may refuse to recertify an
3 independent review organization, if the commissioner finds that the independent
4 review organization is unqualified or has violated an insurance statute or rule or a
5 valid order of the commissioner under s. 601.41 (4), or if the independent review
6 organization's methods or practices in the conduct of its business endanger, or its
7 financial resources are inadequate to safeguard, the legitimate interests of
8 consumers and the public. The commissioner may summarily suspend an
9 independent review organization's certification under s. 227.51 (3).

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

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

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

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

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

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

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

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1 7. Standards for contracts between insurers and independent review
2 organizations.

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

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

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

12 1. A health benefit plan.

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

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

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

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

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

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

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

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

8 6. The insured or his or her authorized representative.

9 **(6m)** QUALIFICATIONS OF CLINICAL PEER REVIEWERS. A clinical peer reviewer who
10 conducts a review on behalf of a certified independent review organization must
11 satisfy all of the following requirements:

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

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

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

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

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1 **(7) IMMUNITY.** (a) A certified independent review organization and a clinical
2 peer reviewer who conducts reviews on behalf of a certified independent review
3 organization shall not be liable in damages to any person for any opinion rendered
4 during or at the completion of an independent review.

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

9 **(8) NOTICE OF SUFFICIENT INDEPENDENT REVIEW ORGANIZATIONS.** The
10 commissioner shall make a determination that a sufficient number of independent
11 review organizations have been certified under sub. (4) to effectively provide the
12 independent reviews required under this section and shall publish a notice in the
13 Wisconsin Administrative Register that states a date that is 6 months after the
14 commissioner makes that determination. The date stated in the notice shall be the
15 date on which the independent review procedure under this section begins operating.

16 **(9) APPLICABILITY.** The independent review required under this section shall be
17 available to an insured who receives notice of the disposition of his or her grievance
18 under s. 632.83 (3) (d) on or after the first day of the 7th month beginning after the
19 effective date of this subsection [revisor inserts date]. Notwithstanding sub. (2)
20 (c), an insured who receives notice of the disposition of his or her grievance under s.
21 632.83 (3) (d) on or after the first day of the 7th month beginning after the effective
22 date of this subsection [revisor inserts date], but before the date stated in the
23 notice published by the commissioner in the Wisconsin Administrative Register
24 under sub. (8) [revisor inserts date], must request an independent review no later

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1 than 4 months after the date stated in the notice published by the commissioner in
2 the Wisconsin Administrative Register under sub. (8) [revisor inserts date].

SECTION 20. Nonstatutory provisions.**(1) RULES REGARDING INDEPENDENT REVIEW.**

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4
5 (a) The commissioner of insurance shall submit in proposed form the rules
6 required under section 632.835 (5) (a) of the statutes, as created by this act, to the
7 legislative council staff under section 227.15 (1) of the statutes no later than the first
8 day of the 7th month beginning after the effective date of this paragraph.

9 (b) Using the procedure under section 227.24 of the statutes, the commissioner
10 of insurance shall promulgate rules required under section 632.835 (5) (a) of the
11 statutes, as created by this act, for the period before the effective date of the
12 permanent rules promulgated under section 632.835 (5) (a) of the statutes, as created
13 by this act, but not to exceed the period authorized under section 227.24 (1) (c) and
14 (2) of the statutes. Notwithstanding section 227.24 (1) (a), (2) (b) and (3) of the
15 statutes, the commissioner is not required to provide evidence that promulgating a
16 rule under this paragraph as an emergency rule is necessary for the preservation of
17 the public peace, health, safety or welfare and is not required to provide a finding of
18 emergency for a rule promulgated under this paragraph.

19 **SECTION 21. Effective dates.** This act takes effect on the day after publication,
20 except as follows:

21 (1) The treatment of sections 609.15 (1) (intro.), (a), (b) and (c) and (2) (intro.),
22 (a), (b), (c), (d) and (e) and 632.83 of the statutes takes effect on the first day of the
23 7th month beginning after publication.

24 (2) The treatment of section 632.835 (2), (3), (3m) and (5) (b) and (c) of the
25 statutes takes effect on the date stated in the notice published by the commissioner

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1 of insurance in the Wisconsin Administrative Register under section 632.835 (8) of
2 the statutes, as created by this act.

3 (END)