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2009 ASSEMBLY BILL 108

March 4, 2009 − Introduced by Representatives PASCH, RICHARDS, BERCEAU, SEIDEL, SHERMAN, YOUNG, HRAYCHUCK and CLARK, cosponsored by Senators VINEHOUT, ERPENBACH, ROBSON, LEHMAN, CARPENTER, WIRCH, TAYLOR, COGGS, HANSEN and MILLER. Referred to Committee on Health and Healthcare Reform.

AN ACT ***to renumber and amend*** 632.835 (3) (f), 632.835 (8) and 632.835 (9); ***to amend*** 632.746 (2) (e), 632.746 (3) (b), 632.835 (title), 632.835 (2) (a), 632.835 (2) (b), 632.835 (2) (bg) 3., 632.835 (2) (c), 632.835 (3) (a), 632.835 (3) (e), 632.835 (3m) (a), 632.835 (6m) (a) and 632.835 (7) (b); and ***to create*** 601.428, 632.835 (1) (ag), 632.835 (1) (cm), 632.835 (2) (e), 632.835 (3) (f) 2., 632.835 (8) (b) and 632.835 (9) (b) of the statutes; **relating to:** portability under group health benefit plans and independent review of insurance policy rescissions and preexisting condition exclusion denials under group and individual health benefit plans.

Analysis by the Legislative Reference Bureau

Under current law, for purposes of determining how long a preexisting condition exclusion may be imposed under a group health benefit plan, if a person who enrolls in the group health benefit plan had other coverage before that enrollment, the person must be given credit for the time during which he or she was previously covered when determining how long a preexisting condition exclusion may be imposed under the new coverage. Previous coverage may not be counted for the credit, however, if the person did not have coverage for a period of 63 or more days

before the person's new coverage commenced. This bill increases that amount of time, so that a person may get credit for previous coverage if it ended up to 90 days, rather than 63 days, before the person enrolled in the group health benefit plan.

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

The bill adds the rescission of a policy or certificate and a coverage denial determination based on a preexisting condition exclusion to the types of adverse decisions that are eligible for review under a group or individual health benefit plan's independent review procedure. In addition, the bill requires every insurer that issues individual health benefit plans to report to the commissioner annually the number of individual health benefit plans issued by the insurer in the preceding year and the number of individual health benefit plans with respect to which the insurer initiated or completed a cancellation or rescission in the preceding year.

For further information see the ***state*** 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. 601.428 of the statutes is created to read:

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

SECTION 2. 632.746 (2) (e) of the statutes is amended to read:

632.746 **(2)** (e) Paragraphs (c) and (d) do not apply to an individual after the end of the first continuous period during which the individual was not covered under any creditable coverage for at least ~~63~~ 90 days. For purposes of this paragraph, any waiting period or affiliation period for coverage under a group health plan or group health benefit plan shall not be taken into account in determining the period before enrollment in the group health plan or group health benefit plan.

SECTION 3. 632.746 (3) (b) of the statutes is amended to read:

632.746 **(3)** (b) With respect to enrollment of an individual under a group health plan or a group health benefit plan, a period of creditable coverage after which the individual was not covered under any creditable coverage for a period of at least ~~63~~ 90 days before enrollment in the group health plan or group health benefit plan may not be counted. For purposes of this paragraph, any waiting period or affiliation period for coverage under the group health plan or group health benefit plan shall not be taken into account in determining the period before enrollment in the group health plan or group health benefit plan.

SECTION 4. 632.835 (title) of the statutes is amended to read:

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

SECTION 5. 632.835 (1) (ag) of the statutes is created to read:

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

SECTION 6. 632.835 (1) (cm) of the statutes is created to read:

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

SECTION 7. 632.835 (2) (a) of the statutes is amended to read:

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

SECTION 8. 632.835 (2) (b) of the statutes is amended to read:

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

SECTION 9. 632.835 (2) (bg) 3. of the statutes is amended to read:

632.835 **(2)** (bg) 3. For any ~~adverse determination or experimental treatment~~ coverage denial determination for which an explanation of benefits is not provided to the insured, the insurer provides a notice that the insured may have a right to an independent review after the internal grievance process and that an insured may be entitled to expedited, independent review with respect to an urgent matter. The

notice shall also include a reference to the section of the policy or certificate that contains the description of the independent review procedure as required under subd. 1. The notice shall provide a toll−free telephone number and website, if appropriate, where consumers may obtain additional information regarding internal grievance and independent review processes.

SECTION 10. 632.835 (2) (c) of the statutes is amended to read:

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

SECTION 11. 632.835 (2) (e) of the statutes is created to read:

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

SECTION 12. 632.835 (3) (a) of the statutes is amended to read:

632.835 **(3)** (a) To request an independent review, an insured or his or her authorized representative shall provide timely written notice of the request for independent review, and of the independent review organization selected, to the insurer that made or on whose behalf was made the ~~adverse or experimental treatment~~ coverage denial determination. The insurer shall immediately notify the commissioner and the independent review organization selected by the insured of the request for independent review. The insured or his or her authorized representative must pay a $25 fee to the independent review organization. If the

insured prevails on the review, in whole or in part, the entire amount paid by the insured or his or her authorized representative shall be refunded by the insurer to the insured or his or her authorized representative. For each independent review in which it is involved, an insurer shall pay a fee to the independent review organization.

SECTION 13. 632.835 (3) (e) of the statutes is amended to read:

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

SECTION 14. 632.835 (3) (f) of the statutes is renumbered 632.835 (3) (f) 1. and amended to read:

632.835 **(3)** (f) 1. If the independent review is not terminated under par. (e), the independent review organization shall, within 30 business days after the expiration of all time limits that apply in the matter, make a decision on the basis of the documents and information submitted under this subsection. The decision shall be in writing, signed on behalf of the independent review organization and served by personal delivery or by mailing a copy to the insured or his or her authorized

representative and to the insurer. ~~A~~ Except as provided in subd. 2., a decision of an independent review organization is binding on the insured and the insurer.

SECTION 15. 632.835 (3) (f) 2. of the statutes is created to read:

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

SECTION 16. 632.835 (3m) (a) of the statutes is amended to read:

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

SECTION 17. 632.835 (6m) (a) of the statutes is amended to read:

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

SECTION 18. 632.835 (7) (b) of the statutes is amended to read:

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

SECTION 19. 632.835 (8) of the statutes is renumbered 632.835 (8) (a) and amended to read:

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

SECTION 20. 632.835 (8) (b) of the statutes is created to read:

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

SECTION 21. 632.835 (9) of the statutes is renumbered 632.835 (9) (a) and amended to read:

632.835 **(9)** (a) *Adverse and experimental treatment determinations.* The independent review required under this section with respect to an adverse determination or an experimental treatment determination shall be available to an insured who receives notice of the disposition of his or her grievance under s. 632.83

(3) (d) on or after December 1, 2000. Notwithstanding sub. (2) (c), an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after December 1, 2000, but before June 15, 2002, with respect to an adverse determination or an experimental treatment determination must request an independent review no later than 4 months after June 15, 2002.

SECTION 22. 632.835 (9) (b) of the statutes is created to read:

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

(END)