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# 2009 SENATE BILL 71

February 18, 2009 − Introduced by Senators VINEHOUT, ERPENBACH, ROBSON, LEHMAN, CARPENTER, WIRCH, TAYLOR, COGGS, HANSEN, MILLER and KREITLOW, cosponsored by Representatives RICHARDS, ROYS, HRAYCHUCK, SEIDEL, CLARK and BERCEAU. Referred to Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue.

AN ACT ***to renumber and amend*** 632.7495 (1) (b); ***to amend*** 631.36 (5) (b) (intro.), 632.76 (2) (a) and 632.76 (2) (b); and ***to create*** 601.41 (10), 631.36 (5) (b) 3., 632.7495 (1) (b) 2. and 632.76 (2) (ac) of the statutes; **relating to:** preexisting condition exclusions, modifications at renewal, and establishing a standard application for individual health benefit plans and granting rule−making authority.

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### *Analysis by the Legislative Reference Bureau*

***Preexisting condition exclusions***

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

an insurer is free to impose a preexisting condition exclusion under an individual health insurance policy for any condition that may have existed at any time during the insured's lifetime that the insurer believes the insured should have known existed or for which the insurer believes the insured should have sought treatment. This bill provides that under an individual health insurance policy, an insurer may impose a preexisting condition exclusion for up to one year for a condition for which an insured received treatment, or for which treatment was recommended, within one year before the insured's coverage began.

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

With some exceptions, an insurer must renew an individual health insurance policy at the option of the insured. At renewal, the insurer may modify the policy form on a uniform basis among all individuals with coverage under that policy form. The bill requires an insurer, at renewal of an individual health insurance policy and at the request of the insured, to modify the benefits or deductible level under the policy, or to provide coverage under a different but comparable individual health insurance policy offered by the insurer without subjecting any individual covered under the policy to additional underwriting.

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

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

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

**SECTION 1.** 601.41 (10) of the statutes is created to read:

601.41 **(10)** UNIFORM APPLICATION FOR INDIVIDUAL HEALTH INSURANCE POLICIES. (a) The commissioner shall by rule prescribe uniform questions and the format for applications, which may not exceed 10 pages in length, for individual major medical health insurance policies.

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

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

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

**SECTION 2.** 631.36 (5) (b) (intro.) of the statutes is amended to read:

631.36 **(5)** (b) *Exception.* (intro.) Paragraph (a) does not apply if the only change that is adverse to the policyholder is a premium increase and if ~~either~~ any of the following applies to the premium increase:

**SECTION 3.** 631.36 (5) (b) 3. of the statutes is created to read:

631.36 **(5)** (b) 3. The premium increase results from a modification in the benefits or deductible level requested by the insured at the time of coverage renewal under s. 632.7495 (1) (b) 2. a.

**SECTION 4.** 632.7495 (1) (b) of the statutes is renumbered 632.7495 (1) (b) (intro.) and amended to read:

632.7495 **(1)** (b) (intro.) At the time of coverage renewal, ~~the~~ all of the following apply:

1. The insurer may modify the individual health benefit plan coverage policy form as long as the modification is consistent with state law and effective on a uniform basis among all individuals with coverage under that policy form.

**SECTION 5.** 632.7495 (1) (b) 2. of the statutes is created to read:

632.7495 **(1)** (b) 2. The insurer shall, at the request of the insured individual, do either of the following:

a. Modify the benefits or deductible level, or both, under the individual health benefit plan that is being renewed.

b. Provide coverage to the insured individual under a different but comparable individual health benefit plan offered by the insurer, without subjecting any individual covered under the individual health benefit plan to additional underwriting.

**SECTION 6.** 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~~ 12 months 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.

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

632.76 **(2)** (ac) An individual disability insurance policy, as defined in s. 632.895 (1) (a), 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 12 months before the effective date of coverage.

**SECTION 8.** 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. ~~A~~ Notwithstanding par. (ac), 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 9. Nonstatutory provisions.**

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

**SECTION 10. Initial applicability.**

(1) MODIFICATIONS AT RENEWAL. The treatment of section 632.7495 (1) (b) 2. of the statutes first applies to individual health benefit plans that are renewed on the effective date of this subsection.

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

**(END)**