2009 DRAFTING REQUEST

Bill

Received: **11/21/2008**

Received By: **pkahler**

Wanted: **As time permits**

Identical to LRB:

For: **Kathleen Vinehout (608) 266-8546**

By/Representing: **Linda Kleinschmidt**

This file may be shown to any legislator: **NO**

Drafter: **pkahler**

May Contact:

Addl. Drafters:

Subject: **Insurance - health**

Extra Copies: **TJD**

Submit via email: **YES**

Requester's email: **Sen.Vinehout@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Changes to individual market (preexisting condition issues; standard application)

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 12/16/2008	bkraft 12/19/2008		_______ _______			
/P1			mduchek 12/19/2008	_______ _______	mbarman 12/19/2008		
/1	pkahler 01/26/2009	bkraft 01/27/2009	jfrantze 01/27/2009	_______ _______	cduerst 01/27/2009	cduerst 01/29/2009	

FE Sent For: NONE

<END>

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/?	pkahler	/P1 bjk 12/19	12/19 ND	12/19 ~~mj~~ RS			

FE Sent For:

<END>

Limit the maximum pre-existing condition exclusion period for the individual market to 1 year.

- 632.76 (2) PREEXISTING DISEASES (a) No claim for loss incurred or disability commencing after ~~2 years~~ 1 year 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.

  - According to a Kaiser Family Foundation Fact Sheet, 9 states use no limit, one state uses 36 months (HI), twelve states use 24 months, one state uses 18 months (MN), twenty three states use 12 months and three states use 9 months.

  - Kaiser explains the "maximum pre-existing condition exclusion period" as a limit on post-claims underwriting. Any claim filed during the exclusion period can be investigated as possibly pre-existing and, if found to be so, can be denied and coverage for all further care for that condition can be excluded during the exclusion period.

Limit the maximum look back period for the individual market to 2 years.

- Current law does not place a limit on the maximum look back period. A 2 year maximum look back period means the following:
  If an insured makes a claim for health care services within the maximum exclusion period, his or her medical history dating back 2 years prior to the purchase of his or her policy can be investigated for evidence that the current health problem existed prior to the purchase of coverage.

  - According to a Kaiser Family Foundation Fact Sheet, 3 other states (FL, IL, WV) use a 2 year maximum look back period. Only 13 states (including WI.) currently use an unlimited look back period. 25 states use a shorter look back period.

  - Kaiser explains the, "maximum look back period" as limiting the period of history preceding purchase of a policy that can be investigated for evidence of a preexisting condition.

Move from the use of the "prudent person standard" to the "objective standard."

only individual ? yes

- With the objective standard in place, an insurer looking at an insured's medical record to determine whether the cause of a disease or physical condition manifested itself prior to the effective date of coverage, can only take into account conditions for which a person received medical advice, diagnosis, care or treatment.

  - Prudent Person: Includes conditions that were never diagnosed, but which exhibited symptoms for which an ordinary prudent person would have sought medical advice, care or treatment. (Kaiser Family Foundation Fact Sheet)

  - Objective Standard: Allows only those conditions for which someone actually received medical advice, diagnosis, care or treatment prior to enrollment to be counted as pre-existing. (Kaiser Family Foundation Fact Sheet)

  - According to a Kaiser Family Foundation Fact Sheet, 18 states use an objective standard for defining a pre-existing condition. Illinois would put the tally at 19, however the chart indicates it uses both the prudent person and objective standards.

3) Individual Market Reform

a) Pre –existing conditions:
   i) Limit exclusions on pre-existing conditions to 12 months (29 other states; 2 states limit to 6 mos.)
   ii) Look Back – limit to 12 months (26 other states)
   iii) Definition of Pre – Existing = Objective Standard (18 states)
   iv) Eliminate Exclusion / Elimination Riders (statutory language allowing additional exclusions 632.76 (2) "…unless the condition was excluded…loss." (13 states prohibit Elimination Riders)
   v) Require insurers to allow policy holders at renewal to modify policy benefits and/or deductible levels or to change coverage to a comparable product

offered by the insurer without being subject to any additional underwriting GA 33-29-9(b)

c) Authorize OCI to create a standardized application for individual health plans. (Oregon has standardized application in place for 6 years; also Washington,

Uniform individual major medical application underwriting questions:

601.41 (10) (a) The commissioner shall by rule prescribe uniform individual major medical health insurance policy underwriting application questions, and the format for application use of those questions. For the purpose of these subsection individual major medical health insurance policy includes health coverage provided on an individual basis through an association.

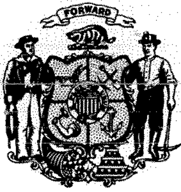
(b) After the effective date of the rule promulgated under this subsection an insurer may use only the prescribed underwriting application questions and format for individual major medical health insurance applications.

submit to leg council w/in a year

rules limit to 10 pages

applies to plans in effect after rule is in effect

publish date in Wis admin code



State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-0912/2
PJK:...:...

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

1 AN ACT ...; **relating to:** preexisting condition exclusions, modifications at
2 renewal, and establishing a standard application for individual health benefit
3 plans and granting rule-making authority.

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 10 pages long. After the effective date of the rules, all insurers writing individual health insurance policies must use the prescribed questions and format on an application for such a policy.

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

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

2 601.41 **(10)** UNIFORM APPLICATION FOR INDIVIDUAL HEALTH INSURANCE POLICIES.
3 (a) The commissioner shall by rule prescribe uniform questions and the format for
4 applications, which may not exceed 10 pages in length, for individual major medical
5 health insurance policies.

6 (b) After the effective date of the rules promulgated under par. (a), an insurer
7 may use only the prescribed questions and format for individual major medical
8 health insurance policy applications. The commissioner shall publish a notice in the
9 Wisconsin Administrative Register that states the effective date of the rules
10 promulgated under par. (a).

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

Insert 3-1

1 SECTION 2. 631.36 (5) (b) 3. of the statutes is created to read:

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

5 SECTION 3. 632.7495 (1) (b) of the statutes is renumbered 632.7495 (1) (b)
6 (intro.) and amended to read:

7 632.7495 **(1)** (b) (intro.) At the time of coverage renewal, ~~the~~ all of the following
8 apply:

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

History: 1997 a. 27, 237.

12 SECTION 4. 632.7495 (1) (b) 2. of the statutes is created to read:

13 632.7495 **(1)** (b) 2. The insurer shall, at the request of the insured individual,
14 do either of the following:

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

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

21 SECTION 5. 632.76 (2) (a) of the statutes is amended to read:

22 632.76 **(2)** (a) No claim for loss incurred or disability commencing after ~~2 years~~
23 12 months from the date of issue of the policy may be reduced or denied on the ground
24 that a disease or physical condition existed prior to the effective date of coverage,

1 unless the condition was excluded from coverage by name or specific description by
2 a provision effective on the date of loss. This paragraph does not apply to a group
3 health benefit plan, as defined in s. 632.745 (9), which is subject to s. 632.746.

History: 1975 c. 375, 421; 1981 c. 82; 1985 a. 29; 1989 a. 31; 1995 a. 289; 1997 a. 27.

4 **SECTION 6.** 632.76 (2) (ac) of the statutes is created to read:

5 632.76 **(2)** (ac) An individual disability insurance policy, as defined in s.
6 632.895 (1) (a), may not define a preexisting condition more restrictively than a
7 condition for which medical advice was given or treatment was recommended by or
8 received from a physician within 12 months before the effective date of coverage.

9 **SECTION 7.** 632.76 (2) (b) of the statutes is amended to read:

10 632.76 **(2)** (b) Notwithstanding par. (a), no claim for loss incurred or disability
11 commencing after 6 months from the date of issue of a medicare supplement policy,
12 medicare replacement policy or long-term care insurance policy may be reduced or
13 denied on the ground that a disease or physical condition existed prior to the effective
14 date of coverage. A Notwithstanding par. (ac), a medicare supplement policy,
15 medicare replacement policy, or long-term care insurance policy may not define a
16 preexisting condition more restrictively than a condition for which medical advice
17 was given or treatment was recommended by or received from a physician within 6
18 months before the effective date of coverage. Notwithstanding par. (a), if on the basis
19 of information contained in an application for insurance a medicare supplement
20 policy, medicare replacement policy, or long-term care insurance policy excludes
21 from coverage a condition by name or specific description, the exclusion must
22 terminate no later than 6 months after the date of issue of the medicare supplement
23 policy, medicare replacement policy, or long-term care insurance policy. The
24 commissioner may by rule exempt from this paragraph certain classes of medicare

1 supplement policies, medicare replacement policies, and long-term care insurance
2 policies, if the commissioner finds the exemption is not adverse to the interests of
3 policyholders and certificate holders.

History: 1975 c. 375, 421; 1981 c. 82; 1985 a. 29; 1989 a. 31; 1995 a. 289; 1997 a. 27.

4 **SECTION 8. Nonstatutory provisions.**

5 (1) RULES. The commissioner of insurance shall submit in proposed form the
6 rules required under section 601.41 (10) (a) of the statutes, as created by this act, to
7 the legislative council staff under section 227.15 (1) of the statutes no later than the
8 first day of the 12th month beginning after the effective date of this subsection.

9 **SECTION 9. Initial applicability.**

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

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

16 **(END)**

D-note

2009-2010 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-0912/?ins
PJK:...:...

INSERT 3-1

1 SECTION 1. 631.36 (5) (b) (intro.) of the statutes is amended to read:

2 631.36 **(5)** (b) *Exception.* (intro.) Paragraph (a) does not apply if the only
3 change that is adverse to the policyholder is a premium increase and if ~~either~~ <u>any</u> of
4 the following applies to the premium increase:

History: 1975 c. 375, 421; 1977 c. 444 s. 11; 1979 c. 102; 1979 c. 110 s. 60 (11); 1981 c. 83; 1985 a. 335; 1989 a. 187, 332, 359; 1991 a. 315; 1995 a. 259; 1997 a. 27; 1999 a. 9; 2007 a. 168.

(END OF INSERT 3-1)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-0912/?dn
PJK:...:...

Because the rules are submitted by the first day of the 12th month beginning after the effective date, there will be less than one full year for promulgating them. If they are submitted by the first day of the 13th month, there will be more than a year. Would you prefer the first day of the 13th month instead of the 12th month?

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266-2682
E-mail: pam.kahler@legis.wisconsin.gov

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-0912/P1dn
PJK:bjk:md

December 19, 2008

Because I provided that the rules must be submitted by the first day of the 12th month beginning after the effective date, there will be less than one full year for promulgating them. If they are submitted by the first day of the 13th month, there will be more than a year. Would you prefer the first day of the 13th month instead of the 12th month?

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Senior Legislative Attorney
Phone: (608) 266-2682
E-mail: pam.kahler@legis.wisconsin.gov

STATE OF WISCONSIN – LEGISLATIVE REFERENCE BUREAU

LRB Research (608–266–0341) Library (608–266–7040) Legal (608–266–3561) LRB

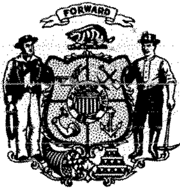
1-26

Linda Kleinschmidt

for LRB-0912, do change

date for submitting proposed

rules to first day of 13th month



State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-0912/1
PJK:bjk:~~md~~

stays
stays
r minor

2009 BILL

change on p 5
(w 1-26)
SOON

SA

regen.

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

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.

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

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

2 601.41 **(10)** UNIFORM APPLICATION FOR INDIVIDUAL HEALTH INSURANCE POLICIES.
3 (a) The commissioner shall by rule prescribe uniform questions and the format for
4 applications, which may not exceed 10 pages in length, for individual major medical
5 health insurance policies.

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

1 Wisconsin Administrative Register that states the effective date of the rules
2 promulgated under par. (a).
3 (c) For purposes of this subsection, an individual major medical health
4 insurance policy includes health coverage provided on an individual basis through
5 an association.
6 **SECTION 2.** 631.36 (5) (b) (intro.) of the statutes is amended to read:
7 631.36 **(5)** (b) *Exception.* (intro.) Paragraph (a) does not apply if the only
8 change that is adverse to the policyholder is a premium increase and if ~~either~~ any of
9 the following applies to the premium increase:
10 **SECTION 3.** 631.36 (5) (b) 3. of the statutes is created to read:
11 631.36 **(5)** (b) 3. The premium increase results from a modification in the
12 benefits or deductible level requested by the insured at the time of coverage renewal
13 under s. 632.7495 (1) (b) 2. a.
14 **SECTION 4.** 632.7495 (1) (b) of the statutes is renumbered 632.7495 (1) (b)
15 (intro.) and amended to read:
16 632.7495 **(1)** (b) (intro.) At the time of coverage renewal, ~~the~~ all of the following
17 apply:
18 1. The insurer may modify the individual health benefit plan coverage policy
19 form as long as the modification is consistent with state law and effective on a
20 uniform basis among all individuals with coverage under that policy form.
21 **SECTION 5.** 632.7495 (1) (b) 2. of the statutes is created to read:
22 632.7495 **(1)** (b) 2. The insurer shall, at the request of the insured individual,
23 do either of the following:
24 a. Modify the benefits or deductible level, or both, under the individual health
25 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

1 months before the effective date of coverage. Notwithstanding par. (a), if on the basis
2 of information contained in an application for insurance a medicare supplement
3 policy, medicare replacement policy, or long–term care insurance policy excludes
4 from coverage a condition by name or specific description, the exclusion must
5 terminate no later than 6 months after the date of issue of the medicare supplement
6 policy, medicare replacement policy, or long–term care insurance policy. The
7 commissioner may by rule exempt from this paragraph certain classes of medicare
8 supplement policies, medicare replacement policies, and long–term care insurance
9 policies, if the commissioner finds the exemption is not adverse to the interests of
10 policyholders and certificate holders.

11 **SECTION 9. Nonstatutory provisions.**

12 (1) RULES. The commissioner of insurance shall submit in proposed form the
13 rules required under section 601.41 (10) (a) of the statutes, as created by this act, to
14 the legislative council staff under section 227.15 (1) of the statutes no later than the
15 first day of the 12th month beginning after the effective date of this subsection.

16 **SECTION 10. Initial applicability.**

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

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

23 **(END)**

Duerst, Christina

From: Kleinschmidt, Linda
Sent: Thursday, January 29, 2009 2:41 PM
To: LRB.Legal
Subject: Draft Review: LRB 09-0912/1 Topic: Changes to individual market (preexisting condition issues; standard application)

Please Jacket LRB 09-0912/1 for the SENATE.