State of Wisconsin
2009 − 2010 LEGISLATURE

LRBs0452/1
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ASSEMBLY SUBSTITUTE AMENDMENT 1,

TO 2009 SENATE BILL 484

April 20, 2010 − Offered by Representative NYGREN.

AN ACT ***to create*** 49.45 (23) (c) and 632.893 of the statutes; **relating to:** health insurance without all mandated benefits for persons on the BadgerCare Plus Core Plan waiting list, providing an exemption from emergency rule procedures, and granting rule−making authority.

Analysis by the Legislative Reference Bureau

Current law contains a number of health insurance coverage requirements that are known as health insurance mandates. A health insurance mandate is defined in current law as a statute that requires an insurance policy to do any of four things: 1) permit a person to obtain treatment or services from a particular type of health care provider; 2) provide coverage for the treatment of a particular disease or condition; 3) provide coverage of a particular type of health care treatment or service, including particular drugs, supplies, or equipment; and 4) provide coverage for a particular type of person based on the person's relationship to the insured.

Current law also authorizes the Department of Health Services (DHS) to establish a Medical Assistance health care benefit plan providing basic primary and preventive care for adults under age 65 who have no dependent children and family incomes not exceeding 200 percent of the poverty line and who are not otherwise eligible for Medical Assistance or Medicare. This plan for childless adults is commonly known as the BadgerCare Plus Core Plan. Due to the volume of applications for the plan, which exceeded the plan's ability to provide benefits for all

who applied, DHS suspended enrollment on October 9, 2009, and established a waiting list.

This substitute amendment authorizes an insurer to offer health insurance coverage in individual policies to individuals who are on the waiting list for the BadgerCare Plus Core Plan. The policies are not required to include all of the health insurance mandates (mandates). The only mandate that is required is that the policy is prohibited from refusing to pay for the services of a particular type of health care provider on the ground that the provider is not a physician unless the policy specifically excludes coverage of the services of those providers, but the policy is also prohibited from excluding the services of chiropractors, whose services may not be excluded under current law.

Under the substitute amendment, an insurer offering the coverage must include with each application a separate form that explains each mandate, the premium cost to include the mandate, and the potential risk of not choosing to include the mandate in the coverage. An applicant must indicate by each mandate's description whether he or she wants to have the mandate included in the coverage. If any new mandates are enacted into law after a policy goes into effect, the insurer must include a separate form with the next renewal notice that provides the same information about the mandate that was provided about each mandate on the separate form included with the application. If the insured does not return the separate form by the later of the time the renewal premium is due or 30 days after the insurer sent the renewal notice, or if the insured fails to indicate whether he or she wants to include the new mandate in the coverage, the insurer must renew the coverage without the new mandate.

The commissioner of insurance must promulgate rules with guidelines for the descriptions of the mandates that insurers must include on the separate forms with applications and renewal notices. DHS must inform individuals who are on the waiting list for the BadgerCare Plus Core Plan about the policies and must establish a process to facilitate enrollment by those who wish to enroll.

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

SECTION 1. 49.45 (23) (c) of the statutes is created to read:

49.45 **(23)** (c) The department shall inform individuals who are on a waiting list for coverage under the demonstration project under this subsection about the individual disability insurance policies offered under s. 632.893 for which they are eligible and shall establish a process to facilitate the enrollment in those policies by those individuals who wish to enroll.

SECTION 2. 632.893 of the statutes is created to read:

632.893 Health care coverage without all mandates. (1) DEFINITIONS. In this section:

(a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(b) "Health care provider" has the meaning given in s. 146.81 (1).

(c) "Insurer" means an insurer that is authorized to do business in this state in one or more lines of insurance that includes health insurance.

(d) "Mandate" means a health insurance mandate, as defined in s. 601.423 (1).

(2) AUTHORITY TO OFFER; ELIGIBILITY; COVERAGE. (a) Except as provided in par. (c) and notwithstanding any other provisions of chs. 600 to 646 to the contrary, an insurer may offer and provide, in accordance with this section, to eligible individuals specified in par. (b), coverage under individual disability insurance policies that do not include any or all mandates.

(b) An individual is eligible for coverage under a disability insurance policy described in par. (a) if the individual is on the waiting list established for the health care benefit plan under s. 49.45 (23).

(c) An insurer may not refuse to provide or pay for benefits under a disability insurance policy under this section for health care services provided by a health care provider on the ground that the services were not rendered by a physician, as defined in s. 990.01 (28), unless the policy clearly excludes services by such health care providers, but no policy under this section may exclude services in violation of s. 632.87 (3).

(3) FORM, INFORMATION, AND CHOICE REQUIREMENTS. (a) An insurer that offers coverage described in sub. (2) (a) shall allow an individual applying for coverage to choose to have the coverage include none, one or more, or all mandates. The

application shall include a separate form that provides a plain−language explanation of the differences between the coverage being offered and health care coverage that is subject to all mandates. The separate form also shall provide, in list form, a plain−language description of each mandate and all of the following information about each mandate:

1. The premium cost to the applicant to include the mandate in the coverage.

2. Why it might be desirable to include the mandate in the coverage.

3. The potential consequences or risk of choosing not to include the mandate in the coverage.

(b) 1. If a mandate is enacted after an individual completes an application, the insurer shall provide at the first renewal of the policy occurring after the mandate is enacted a renewal notice that includes a separate form, to be returned to the insurer, that describes each mandate enacted since the application was completed or the last renewal of the policy, whichever is later, and that includes the information under par. (a) 1. to 3. with respect to the mandate.

2. The separate form provided with a renewal notice shall be returned to the insurer by the time the premium for renewal is due, or within 30 days after the renewal notice and separate form are sent by the insurer, whichever is later.

(c) 1. Each description of a mandate on the separate form under par. (a) or (b) listing the mandates shall be followed by a line on which the individual must indicate "yes" or "no" as to whether the mandate should be included in the coverage. The form shall include a line for the signature of the applicant or insured and shall be a part of the signed application or renewal form.

2. If an individual fails to timely return a form that was sent with a renewal notice, or timely returns the form but fails to indicate on the form a "yes" or "no" as

to whether a mandate should be included in the coverage, the failure constitutes an agreement to continue the coverage on its existing terms without the mandate.

3. The plain−language explanation on a form under par. (a) of coverage differences and the plain−language description on a form under par. (a) or (b) of a mandate and the information under par. (a) 1. to 3. shall comply with guidelines established by the commissioner by rule under sub. (4).

(4) RULES. The commissioner shall, by rule, promulgate guidelines for the plain−language explanation required under sub. (3) (a) of coverage differences and for the plain−language descriptions and other information required under sub. (3) (a) and (b) relating to the mandates.

SECTION 3. Nonstatutory provisions.

(1) EMERGENCY RULES. Using the procedure under section 227.24 of the statutes, the commissioner of insurance may promulgate rules required under section 632.893 (4) of the statutes, as created by this act, for the period before the effective date of the permanent rules promulgated under section 632.893 (4) of the statutes, as created by this act, but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) (a), (2) (b), and (3) of the statutes, the commissioner is not required to provide evidence that promulgating a rule under this subsection as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this subsection.

SECTION 4. Initial applicability.

(1) This act first applies to policies offered on the effective date of this subsection.

(END)