



2011 ASSEMBLY BILL 210

July 29, 2011 – Introduced by Representative PETERSEN. Referred to Committee on Insurance.

1 **AN ACT to repeal** 609.755, 632.83, 632.835 and 632.885; **to renumber** 625.02 (1);
2 **to renumber and amend** 625.03 (1m) (e); **to amend** 40.51 (8), 40.51 (8), 40.51
3 (8m), 40.51 (8m), 49.67 (3) (am) 2. b., 66.0137 (4), 66.0137 (4), 111.91 (2) (n),
4 111.91 (2) (nm), 111.91 (2) (s), 111.998 (2) (n), 111.998 (2) (s), 120.13 (2) (g),
5 120.13 (2) (g), 185.983 (1) (intro.), 185.983 (1) (intro.), 600.01 (2) (b), 601.31 (1)
6 (Lp), 601.31 (1) (Lr), 601.42 (4), 609.655 (4) (b), 625.13 (1), 625.14, 632.76 (2) (ac)
7 1., 632.76 (2) (ac) 2., 632.76 (2) (ac) 3. (intro.) and 632.895 (15) (c) (intro.); and
8 **to create** 601.465 (1m) (d), 625.02 (1h), 625.02 (1p), 625.02 (2f), 625.02 (2s),
9 625.03 (1m) (e) 2., 625.03 (1m) (e) 3., 625.13 (3), 632.76 (2) (ac) 4. and chapter
10 636 of the statutes; **relating to:** implementing health insurance reform,
11 providing an exemption from emergency rule procedures, and granting
12 rule-making authority.

Analysis by the Legislative Reference Bureau

This bill incorporates the health insurance coverage requirements of the federal Patient Protection and Affordable Care Act (PPACA) into the Wisconsin

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statutes. The bill requires insurers to comply with PPACA provisions that went into effect for plan years beginning on or after March 23, 2010, relating to all of the following: 1) standards relating to benefits for mothers and newborns; 2) required coverage for reconstructive surgery following a mastectomy; and 3) coverage of a dependent student on a medically necessary leave of absence. The bill requires insurers to comply with PPACA provisions that went into effect for plan years beginning on or after September 23, 2010, relating to all of the following: 1) prohibiting annual or lifetime limits; 2) prohibiting coverage rescissions; 3) prohibiting preexisting condition exclusions for individuals under age 19; 4) coverage of certain preventive health services without cost-sharing; 5) extension of coverage to dependents up to age 26; 6) the provision of additional information; 7) giving plan enrollees choice as to a primary care provider; and 8) coverage of emergency services without prior authorization. In addition, the bill requires insurers to comply with PPACA provisions for plan years beginning on or after March 23, 2012, relating to all of the following: 1) the development and use of uniform explanation of coverage documents and standardized definitions; and 2) requirements for ensuring the quality of care. The bill also requires insurers to comply with the PPACA requirement to file a report for each plan year concerning the ratio of incurred loss, plus loss adjustment expense, to earned premiums and to provide a rebate to enrollees under certain circumstances. Under PPACA, the provisions apply to insurers offering medical care benefits under any hospital or medical service policy or plan contract.

A health care policy or plan that was in effect when PPACA was enacted is called a grandfathered health plan. The bill specifically requires a grandfathered health plan to comply, when the grandfathered health plan is renewed, with the following PPACA provisions: 1) coverage of a dependent student on a medically necessary leave of absence; 2) coverage of certain preventive health services without cost-sharing; 3) coverage of emergency services without prior authorization; and 4) at renewal on or after March 23, 2012, requirements for ensuring the quality of care. The bill provides that the additional requirements under the bill with which insurers must comply apply to grandfathered health plans only with respect to those requirements that apply to grandfathered health plans under PPACA.

Current law requires health insurers to cover emergency services without prior authorization, breast reconstruction after a mastectomy, dependent coverage of a student while on a medically necessary leave of absence, and colorectal screening. These coverage provisions are consistent with, and therefore duplicative of, the relevant PPACA requirements and are not repealed in the bill. Current law also requires health insurers to provide coverage of a dependent up to age 27, or up to any age if the dependent is a student and had to leave school previously because he or she was called to active duty in the armed forces. PPACA requires coverage of a dependent up to age 26 and has no additional requirement related to a student previously called to active duty. Because of this inconsistency, the current law dependent coverage provision is repealed in the bill. The bill specifies that, if PPACA is found by a final decision of a federal court of competent jurisdiction to be unconstitutional in its entirety and unenforceable in this state, after all appeals have

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been exhausted or the time for appeal has expired insurers are exempt from the PPACA coverage requirements incorporated into the bill, with the exception of the provision related to dependent coverage. Thus, if PPACA were found unconstitutional, in addition to the dependent coverage requirement, insurers would be subject to the coverage requirements in current law that are consistent with PPACA and that have not been repealed in the bill.

Under current law, a health insurer must have an internal grievance procedure and an independent review procedure whereby an insured person may appeal certain types of coverage denials to an independent review organization. The statutes set out criteria for both procedures and provide for certification of independent review organizations by the commissioner of insurance (commissioner). The bill repeals these provisions and requires the commissioner to establish standards by rule for both internal and external appeals that are consistent with requirements under PPACA. The requirements for internal appeals apply to all group and individual health insurance policies, grandfathered health plans, policies providing limited-scope dental or vision benefits, and hospital or fixed indemnity policies. The requirements for external appeals apply to all group and individual health insurance policies, grandfathered health plans, hospital or fixed indemnity policies, and Medicare supplement or replacement policies, excluding Medicare advantage plans. An independent review organization performing external appeals must be certified by the commissioner, who may revoke, suspend, or limit the certification or refuse to recertify under specified conditions. An independent review organization must have a quality assurance mechanism to ensure timely and independent reviews and may charge reasonable fees, which must be approved by the commissioner. The commissioner has authority to examine and audit an independent review organization's books and records. A decision of an independent review organization is binding on the insured and the insurer. An independent review organization is immune from any liability that may result from an independent review determination, and an insurer is not liable for any damages attributable to actions taken in compliance with an independent review organization determination.

Under current law, rates for insurance must be filed with the commissioner within 30 days after they become effective, and the commissioner may disapprove a rate after it has been filed. Certain types of insurance, including group and blanket accident and sickness insurance, are exempt from the rating requirement provisions, including the requirement to file rates. The bill provides that, beginning on September 1, 2011, group health insurance offered to employers with not more than 50 employees (small employer health insurance) and group and blanket accident and sickness insurance offered in the individual market are not exempt from the rating requirement provisions. In addition, the bill requires that rates for individual health insurance, small employer health insurance, and group and blanket accident and sickness insurance offered in the individual market be filed with the commissioner before, rather than after, they become effective.

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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), 631.95, 632.72 (2), 632.746 (1) to (8)
4 and (10), 632.747, 632.748, 632.798, ~~632.83, 632.835,~~ 632.85, 632.853, 632.855,
5 632.87 (3) to (6), 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896 and, so
6 far as applicable, ch. 636.

7 **SECTION 2.** 40.51 (8) of the statutes, as affected by 2011 Wisconsin Act (this
8 act), is amended to read:

9 40.51 (8) Every health care coverage plan offered by the state under sub. (6)
10 shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8)
11 and (10), 632.747, 632.748, 632.798, 632.85, 632.853, 632.855, 632.87 (3) to (6),
12 ~~632.885,~~ 632.89, 632.895 (5m) and (8) to (17), and 632.896 and, so far as applicable,
13 ch. 636.

14 **SECTION 3.** 40.51 (8m) of the statutes is amended to read:

15 40.51 (8m) Every health care coverage plan offered by the group insurance
16 board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747,
17 632.748, 632.798, ~~632.83, 632.835,~~ 632.85, 632.853, 632.855, 632.885, 632.89, and
18 632.895 (11) to (17) and, so far as applicable, ch. 636.

19 **SECTION 4.** 40.51 (8m) of the statutes, as affected by 2011 Wisconsin Act (this
20 act), 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. 631.95, 632.746 (1) to (8) and (10), 632.747,
3 632.748, 632.798, 632.85, 632.853, 632.855, ~~632.885~~, 632.89, and 632.895 (11) to (17)
4 and, so far as applicable, ch. 636.

5 **SECTION 5.** 49.67 (3) (am) 2. b. of the statutes, as affected by 2011 Wisconsin
6 Act 32, is amended to read:

7 49.67 **(3)** (am) 2. b. If the applicant is under 26 years of age, notice that he or
8 she may be eligible for coverage as a dependent under his or her parent's health care
9 plan in accordance with s. ~~632.885~~ 636.25 (1) (h) or (3) (b), and that his or her parent's
10 plan must include coverage for services that are not covered under the plan under
11 this section.

12 **SECTION 6.** 66.0137 (4) of the statutes is amended to read:

13 66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or
14 a village provides health care benefits under its home rule power, or if a town
15 provides health care benefits, to its officers and employees on a self-insured basis,
16 the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),
17 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87
18 (4), (5), and (6), ~~632.885~~, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4) and, so
19 far as applicable, ch. 636.

20 **SECTION 7.** 66.0137 (4) of the statutes, as affected by 2011 Wisconsin Act ...
21 (this act), is amended to read:

22 66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or
23 a village provides health care benefits under its home rule power, or if a town
24 provides health care benefits, to its officers and employees on a self-insured basis,
25 the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),

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1 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87
2 (4), (5), and (6), ~~632.885~~, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4) and, so
3 far as applicable, ch. 636.

4 **SECTION 8.** 111.91 (2) (n) of the statutes is amended to read:

5 111.91 (2) (n) The provision to employees of the health insurance coverage
6 required under s. 632.895 (11) to (14), (16), ~~and (16m)~~, and (17) and, so far as
7 applicable, s. 636.25.

8 **SECTION 9.** 111.91 (2) (nm) of the statutes is amended to read:

9 111.91 (2) (nm) The requirements related to ~~providing coverage for a dependent~~
10 ~~under s. 632.885 and to continuing coverage for a dependent student on a medical~~
11 ~~leave of absence under s. 632.895 (15).~~

12 **SECTION 10.** 111.91 (2) (s) of the statutes is amended to read:

13 111.91 (2) (s) The requirements related to ~~internal grievance procedures under~~
14 ~~s. 632.83 and independent review~~ and external appeals of certain health benefit plan
15 determinations established under s. ~~632.835~~ 636.12.

16 **SECTION 11.** 111.998 (2) (n) of the statutes is amended to read:

17 111.998 (2) (n) The provision to employees of the health insurance coverage
18 required under s. 632.895 (11) to (14) and, so far as applicable, s. 636.25.

19 **SECTION 12.** 111.998 (2) (s) of the statutes is amended to read:

20 111.998 (2) (s) The requirements related to ~~internal grievance procedures~~
21 ~~under s. 632.83 and independent review~~ and external appeals of certain health
22 benefit plan determinations established under s. ~~632.835~~ 636.12.

23 **SECTION 13.** 120.13 (2) (g) of the statutes is amended to read:

24 120.13 (2) (g) Every self-insured plan under par. (b) shall comply with ss.
25 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),

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1 632.798, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.885, 632.89, 632.895
2 (9) to (17), 632.896, and 767.513 (4) and, so far as applicable, ch. 636.

3 **SECTION 14.** 120.13 (2) (g) of the statutes, as affected by 2011 Wisconsin Act
4 (this act), is amended to read:

5 120.13 (2) (g) Every self-insured plan under par. (b) shall comply with ss.
6 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),
7 632.798, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), ~~632.885~~, 632.89, 632.895
8 (9) to (17), 632.896, and 767.513 (4) and, so far as applicable, ch. 636.

9 **SECTION 15.** 185.983 (1) (intro.) of the statutes is amended to read:

10 185.983 (1) (intro.) Every voluntary nonprofit health care plan operated by a
11 cooperative association organized under s. 185.981 shall be exempt from chs. 600 to
12 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44,
13 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93,
14 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85,
15 632.853, 632.855, 632.87 (2), (2m), (3), (4), (5), and (6), 632.885, 632.89, 632.895 (5)
16 and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 625, 630, 635, 636, 645,
17 and 646, but the sponsoring association shall:

18 **SECTION 16.** 185.983 (1) (intro.) of the statutes, as affected by 2011 Wisconsin
19 Act (this act), is amended to read:

20 185.983 (1) (intro.) Every voluntary nonprofit health care plan operated by a
21 cooperative association organized under s. 185.981 shall be exempt from chs. 600 to
22 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44,
23 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93,
24 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85,
25 632.853, 632.855, 632.87 (2), (2m), (3), (4), (5), and (6), ~~632.885~~, 632.89, 632.895 (5)

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1 and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 625, 630, 635, 636, 645,
2 and 646, but the sponsoring association shall:

3 **SECTION 17.** 600.01 (2) (b) of the statutes is amended to read:

4 600.01 (2) (b) Group or blanket insurance described in sub. (1) (b) 3. and 4. is
5 not exempt from ss. 632.745 to 632.749, ~~632.83 or 632.835~~ or 636.12 or ch. 633 or 635.

6 **SECTION 18.** 601.31 (1) (Lp) of the statutes is amended to read:

7 601.31 (1) (Lp) For certifying as an independent review organization under s.
8 ~~632.835~~ 636.15 (1) (a), \$400.

9 **SECTION 19.** 601.31 (1) (Lr) of the statutes is amended to read:

10 601.31 (1) (Lr) For each biennial recertification as an independent review
11 organization under s. ~~632.835~~ 636.15 (1) (a), \$100.

12 **SECTION 20.** 601.42 (4) of the statutes is amended to read:

13 601.42 (4) REPLIES. Any officer, manager or general agent of any insurer
14 authorized to do or doing an insurance business in this state, any person controlling
15 or having a contract under which the person has a right to control such an insurer,
16 whether exclusively or otherwise, any person with executive authority over or in
17 charge of any segment of such an insurer's affairs, any individual practice
18 association or officer, director or manager of an individual practice association, any
19 insurance agent or other person licensed under chs. 600 to 646, any provider of
20 services under a continuing care contract, as defined in s. 647.01 (2), any
21 independent review organization certified or recertified under s. ~~632.835 (4)~~ 636.15
22 (1) (a) or any health care provider, as defined in s. 655.001 (8), shall reply promptly
23 in writing or in other designated form, to any written inquiry from the commissioner
24 requesting a reply.

25 **SECTION 21.** 601.465 (1m) (d) of the statutes is created to read:

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1 601.465 **(1m)** (d) Information contained in individual or small group health
2 insurance rate and supplementary rate information filed under ch. 625 that the
3 office determines is proprietary.

4 **SECTION 22.** 609.655 (4) (b) of the statutes is amended to read:

5 609.655 **(4)** (b) Upon completion of the review under par. (a), the medical
6 director of the defined network plan shall determine whether the policy or certificate
7 will provide coverage of any further treatment for the dependent student's nervous
8 or mental disorder or alcoholism or other drug abuse problems that is provided by
9 a provider located in reasonably close proximity to the school in which the student
10 is enrolled. If the dependent student disputes the medical director's determination,
11 the dependent student may submit a written grievance under the defined network
12 plan's internal grievance procedure established under s. ~~632.83~~ 636.12.

13 **SECTION 23.** 609.755 of the statutes is repealed.

14 **SECTION 24.** 625.02 (1) of the statutes is renumbered 625.02 (1m).

15 **SECTION 25.** 625.02 (1h) of the statutes is created to read:

16 625.02 **(1h)** "Individual health insurance coverage" has the meaning given in
17 s. 636.01 (4).

18 **SECTION 26.** 625.02 (1p) of the statutes is created to read:

19 625.02 **(1p)** "Public Health Service Act" has the meaning given in s. 636.01 (9).

20 **SECTION 27.** 625.02 (2f) of the statutes is created to read:

21 625.02 **(2f)** "Secretary" means the secretary of the federal department of health
22 and human services.

23 **SECTION 28.** 625.02 (2s) of the statutes is created to read:

24 625.02 **(2s)** "Small employer health insurance" means health insurance
25 coverage as defined in s. 636.01 (3) that is offered in the small group market as

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1 defined in section 2791 (e) (5) of the Public Health Service Act (42 USC 300gg-91 (e)
2 (5)). For purposes of this subsection, a small employer is an employer that employed
3 an average of at least one but not more than 50 employees on business days during
4 the preceding calendar year and that employs at least one employee on the first day
5 of the plan year.

6 **SECTION 29.** 625.03 (1m) (e) of the statutes is renumbered 625.03 (1m) (e)
7 (intro.) and amended to read:

8 625.03 (1m) (e) (intro.) Group and blanket accident and sickness insurance
9 ~~other than credit, except for the following:~~

10 1. Credit accident and sickness insurance.

11 **SECTION 30.** 625.03 (1m) (e) 2. of the statutes is created to read:

12 625.03 (1m) (e) 2. Subject to s. 636.35, on and after September 1, 2011, small
13 employer health insurance, unless the commissioner provides otherwise by rule,
14 including emergency rule as provided in s. 636.10 (2).

15 **SECTION 31.** 625.03 (1m) (e) 3. of the statutes is created to read:

16 625.03 (1m) (e) 3. Subject to s. 636.35, on and after September 1, 2011, group
17 and blanket accident and sickness insurance offered in the individual market, as
18 defined in s. 636.01 (5), unless the commissioner provides otherwise by rule,
19 including emergency rule as provided in s. 636.10 (2).

20 **SECTION 32.** 625.13 (1) of the statutes is amended to read:

21 625.13 (1) FILING PROCEDURE. Except as provided in ~~sub.~~ subs. (2) and (3), every
22 authorized insurer and every rate service organization licensed under s. 625.31
23 which has been designated by any insurer for the filing of rates under s. 625.15 (2)
24 shall file with the commissioner all rates and supplementary rate information and

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1 all changes and amendments thereof made by it for use in this state within 30 days
2 after they become effective.

3 **SECTION 33.** 625.13 (3) of the statutes is created to read:

4 625.13 (3) INDIVIDUAL AND SMALL EMPLOYER HEALTH INSURANCE. Subject to s.
5 636.35, on and after September 1, 2011, unless the commissioner provides otherwise
6 by rule, including emergency rule as provided in s. 636.10 (2), for individual health
7 insurance coverage, group and blanket accident and sickness insurance offered in
8 the individual market, or small employer health insurance an insurer, or a rate
9 service organization licensed under s. 625.31 that has been designated by the insurer
10 for the filing of rates under s. 625.15 (2), shall file with the commissioner all rates
11 and supplementary rate information, and all changes and amendments to the
12 information, before they become effective.

13 **SECTION 34.** 625.14 of the statutes is amended to read:

14 **625.14 Filings open to inspection.** ~~Each~~ Subject to s. 601.465 (1m) (d), each
15 filing and any supporting information filed under this chapter shall, as soon as filed,
16 be open to public inspection at any reasonable time. Copies may be obtained by any
17 person on request and upon payment of a reasonable charge therefor.

18 **SECTION 35.** 632.76 (2) (ac) 1. of the statutes is amended to read:

19 632.76 (2) (ac) 1. Notwithstanding par. (a) and except as provided in subd. 4.,
20 no claim or loss incurred or disability commencing after 12 months from the date of
21 issue of an individual disability insurance policy, as defined in s. 632.895 (1) (a), may
22 be reduced or denied on the ground that a disease or physical condition existed prior
23 to the effective date of coverage, unless the condition was excluded from coverage by
24 name or specific description by a provision effective on the date of the loss.

25 **SECTION 36.** 632.76 (2) (ac) 2. of the statutes is amended to read:

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1 632.76 (2) (ac) 2. Except as provided in ~~subd.~~ subds. 3. and 4., an individual
2 disability insurance policy, as defined in s. 632.895 (1) (a), other than a short-term
3 policy subject to s. 632.7495 (4) and (5), may not define a preexisting condition more
4 restrictively than a condition, whether physical or mental, regardless of the cause
5 of the condition, for which medical advice, diagnosis, care, or treatment was
6 recommended or received within 12 months before the effective date of coverage.

7 **SECTION 37.** 632.76 (2) (ac) 3. (intro.) of the statutes is amended to read:

8 632.76 (2) (ac) 3. (intro.) Except as provided in subd. 4. and except as the
9 commissioner provides by rule under s. 632.7495 (5), all of the following apply to an
10 individual disability insurance policy that is a short-term policy subject to s.
11 632.7495 (4) and (5):

12 **SECTION 38.** 632.76 (2) (ac) 4. of the statutes is created to read:

13 632.76 (2) (ac) 4. Subdivisions 1., 2., and 3. do not apply to an individual
14 disability insurance policy, as defined in s. 632.895 (1) (a), issued on or after
15 September 23, 2010, and before January 1, 2014, that covers an individual who is
16 under 19 years of age, with respect to coverage of that individual. Section 636.25 (1)
17 (f) applies to such a policy with respect to coverage of that individual.

18 **SECTION 39.** 632.83 of the statutes is repealed.

19 **SECTION 40.** 632.835 of the statutes is repealed.

20 **SECTION 41.** 632.885 of the statutes, as affected by 2011 Wisconsin Act 32, is
21 repealed.

22 **SECTION 42.** 632.895 (15) (c) (intro.) of the statutes is amended to read:

23 632.895 (15) (c) (intro.) A Except as otherwise required under s. 636.25 (1) (c),
24 (2) (a), or (3) (a), a policy or plan is required to continue coverage under par. (a) only
25 until any of the following occurs:

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1 **SECTION 43.** Chapter 636 of the statutes is created to read:

2 **CHAPTER 636**

3 **HEALTH INSURANCE REFORM**

4 **636.01 Definitions.** In this chapter, unless the context requires otherwise:

5 (1) "Defined network plan" has the meaning given in s. 609.01 (1b).

6 (2) "Grandfathered health plan" has the meaning given in section 1251 (e) of
7 the Patient Protection and Affordable Care Act.

8 (3) "Health insurance coverage" has the meaning given in section 2791 (b) (1)
9 of the Public Health Service Act (42 USC 300gg-91 (b) (1)). "Health insurance
10 coverage" includes coverage issued by an insurer and insurance that is a group
11 health plan, as defined in section 2791 (a) (1) of the Public Health Service Act (42
12 USC 300gg-91 (a) (1)). "Health insurance coverage" does not include excepted
13 benefits that are excluded under section 2722 (b) or (c) of the Public Health Service
14 Act (42 USC 300gg-21 (b) or (c)).

15 (4) "Individual health insurance coverage" means health insurance coverage
16 offered to individuals in the individual market. "Individual health insurance
17 coverage" does not include short-term limited duration insurance.

18 (5) "Individual market" has the meaning given in section 1304 (a) (2) of the
19 Patient Protection and Affordable Care Act.

20 (6) "Limited-scope dental or vision benefits" means limited-scope dental or
21 vision benefits provided under a separate policy, certificate, or contract of insurance
22 or plan, or otherwise not provided as an integral part of the policy, certificate, or
23 contract of insurance or plan.

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1 (7) “Patient Protection and Affordable Care Act” means the federal Patient
2 Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health
3 Care and Education Reconciliation Act of 2010, P.L. 111-152.

4 (8) “Preexisting condition exclusion denial determination” means a
5 determination by or on behalf of an insurer that issues a health benefit plan denying
6 or terminating treatment or payment for treatment on the basis of a preexisting
7 condition exclusion, as defined in s. 632.745 (23).

8 (9) “Public Health Service Act” means the federal Public Health Service Act of
9 1944, as amended, including by the Patient Protection and Affordable Care Act (42
10 USC 300gg et seq.).

11 (10) “Secretary” means the secretary of the federal department of health and
12 human services.

13 (11) “Self-insured governmental health plan” means a self-insured health
14 plan of the state or a county, city, village, town, or school district.

15 (12) “Small employer health insurance” means health insurance coverage
16 offered in the small group market as defined in section 2791 (e) (5) of the Public
17 Health Service Act (42 USC 300gg-91 (e) (5)) and section 1304 (a) (3) of the Patient
18 Protection and Affordable Care Act, as applied by the secretary’s regulation for the
19 purposes of section 2718 of the Public Health Service Act (42 USC 300gg-18). For
20 purposes of this definition, in section 1304 (a) (3) of the Patient Protection and
21 Affordable Care Act, “small employer” has the meaning given in section 1304 (b) (2)
22 of that act.

23 **636.10 General provisions. (1) AUTHORITY IS ADDITIONAL.** The
24 commissioner’s authority under this chapter is in addition to any authority
25 otherwise provided under chs. 600 to 635 and chs. 644 to 646. The commissioner may

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1 by rule establish standards for compliance with this chapter. The commissioner may
2 establish reporting requirements for the purpose of monitoring or enforcing
3 compliance with this chapter and rules adopted under this chapter.

4 **(2) EMERGENCY RULE-MAKING.** Using the procedure under s. 227.24, the
5 commissioner may promulgate any rule under this chapter or under s. 625.03 (1m)
6 (e) 2. or 3. or 625.13 (3) as an emergency rule. Notwithstanding s. 227.24 (1) (c), any
7 emergency rule promulgated under this subsection may remain in effect for up to one
8 year and, in addition, may be extended under s. 227.24 (2). Notwithstanding s.
9 227.24 (1) (a), (2) (b), and (3), the commissioner is not required to provide evidence
10 that promulgating a rule under this subsection as an emergency rule is necessary for
11 the preservation of public peace, health, safety, or welfare and is not required to
12 provide a finding of emergency for a rule promulgated under this subsection.

13 **(3) EMPLOYER SIZE ELECTION.** Notwithstanding s. 636.01 (12), this state reserves
14 the right to elect, as permitted under section 1304 (b) (3) of the Patient Protection and
15 Affordable Care Act, to substitute “51 employees” for “101 employees” and “50
16 employees” for “100 employees,” after the effective date of this subsection [LRB
17 inserts date], for any purpose permitted under the Public Health Service Act.

18 **636.12 Internal and external appeals. (1) ESTABLISHING STANDARDS.**
19 Notwithstanding any inconsistent provision of chs. 600 to 635 or chs. 644 to 646, the
20 commissioner shall by rule do all of the following:

21 (a) Establish standards for internal appeals that, at a minimum, include
22 consumer protections consistent with section 2719 (a) of the Public Health Service
23 Act (42 USC 300gg-19 (a)), and require an insurer to comply with the standards. The
24 commissioner shall apply the standards established under this paragraph to all of
25 the following:

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1 1. Group and individual health insurance coverage subject to section 2719 (a)
2 of the Public Health Service Act (42 USC 300gg-19 (a)).

3 2. Grandfathered health plans that otherwise would be subject to section 2719
4 (a) of the Public Health Service Act (42 USC 300gg-19 (a)).

5 3. A policy, certificate, or contract that provides only limited-scope dental or
6 vision benefits.

7 4. Coverage specified in s. 632.745 (11) (b) 10.

8 (b) Establish standards for external appeals, including standards for appealing
9 a preexisting condition exclusion denial determination or the rescission of a policy
10 or certificate, and require an insurer to comply with the standards. The
11 commissioner shall adopt standards under this paragraph that comply either with
12 section 2719 (b) (1) of the Public Health Service Act (42 USC 300gg-19 (b) (1)) or with
13 the standards established by the secretary under section 2719 (b) (2) of the Public
14 Health Service Act (42 USC 300gg-19 (b) (2)). The commissioner shall apply the
15 external appeal standards established under this paragraph to all of the following:

16 1. Group and individual health insurance coverage subject to section 2719 (b)
17 of the Public Health Service Act (42 USC 300gg-19 (b)).

18 2. Grandfathered health plans.

19 3. Coverage specified in s. 632.745 (11) (b) 10.

20 4. Coverage specified in s. 632.745 (11) (b) 11., including Medicare supplement
21 or replacement policies, but excluding Medicare advantage plans.

22 (c) Establish standards for independent review organizations.

23 **(2) COMPLIANCE REQUIRED.** An insurer and an independent review organization
24 shall comply with the rules promulgated under this chapter.

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1 **636.15 Independent review organizations. (1) CERTIFICATION.** (a) An
2 independent review organization may not perform a review for purposes of the
3 external appeals process established in accordance with standards promulgated
4 under s. 636.12 (1) (b) unless the organization is certified by the commissioner.
5 Unless the commissioner provides otherwise by rule, only an independent review
6 organization that is accredited by a nationally recognized private accreditation
7 organization may be certified under this paragraph. An independent review
8 organization must demonstrate to the satisfaction of the commissioner that it is
9 unbiased and does not have a conflict of interest, as defined by the commissioner by
10 rule. An organization certified under this paragraph must be recertified on a
11 biennial basis.

12 (b) An organization applying for certification or recertification as an
13 independent review organization shall pay the applicable fee under s. 601.31 (1) (Lp)
14 or (Lr). Every organization certified or recertified as an independent review
15 organization shall file a report with the commissioner in accordance with rules
16 promulgated under s. 636.12 (1) (c).

17 (c) An independent review organization that was certified or recertified by the
18 commissioner under s. 632.835, 2009 stats., and whose certification is in effect on the
19 effective date of this paragraph [LRB inserts date], shall be considered to have
20 been certified under par. (a), and its certification shall remain in effect until the
21 certification expires or it is revoked or suspended under sub. (5) or s. 227.51 (3).

22 **(2) QUALITY ASSURANCE MECHANISM.** An independent review organization shall
23 have in operation a quality assurance mechanism to ensure the timeliness and
24 quality of the independent reviews, the qualifications and independence of the

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1 clinical peer reviewers, and the confidentiality of the medical records and review
2 materials.

3 (3) REASONABLE FEES. An independent review organization shall establish
4 reasonable fees that it will charge for independent reviews and shall submit its fee
5 schedule to the commissioner for a determination of reasonableness and for prior
6 approval. An independent review organization may not change any fees approved
7 by the commissioner more than once per year and shall submit any proposed fee
8 changes to the commissioner for prior approval.

9 (4) EXAMINATIONS AND AUDITS. The commissioner may examine, audit, or accept
10 an audit of, the books and records of an independent review organization as provided
11 for examination of licensees and permittees under s. 601.43 (1), (3), (4), and (5), to
12 be conducted as provided in s. 601.44, and with costs to be paid as provided in s.
13 601.45.

14 (5) REVOCATION, SUSPENSION, REFUSAL TO RECERTIFY. The commissioner may
15 revoke, suspend, or limit in whole or in part the certification of an independent
16 review organization, or may refuse to recertify an independent review organization,
17 if the commissioner finds that the independent review organization is unqualified
18 or has violated a statute, or a rule promulgated, under chs. 600 to 646 or a valid order
19 of the commissioner under s. 601.41 (4), or if the independent review organization's
20 methods or practices in the conduct of its business endanger, or its financial
21 resources are inadequate to safeguard, the legitimate interests of consumers and the
22 public. The commissioner may summarily suspend an independent review
23 organization's certification under s. 227.51 (3).

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1 **(6) DECISION IS BINDING.** Unless otherwise required by the standards under
2 section 2719 (b) of the Public Health Service Act (42 USC 300gg-19 (b)), a decision
3 of an independent review organization is binding on the insured and the insurer.

4 **(7) IMMUNITY FROM LIABILITY.** (a) An independent review organization that is
5 certified under this section is immune from any civil or criminal liability that may
6 result because of an independent review determination made under the rules
7 promulgated under this chapter. An employee, agent, or contractor of a certified
8 independent review organization is immune from any civil or criminal liability for
9 any act or omission done in good faith within the scope of his or her powers and duties
10 under the rules promulgated under this chapter.

11 (b) An insurer is not liable to any person for damages attributable to the
12 insurer's actions taken in compliance with any decision regarding a determination
13 rendered by a certified independent review organization.

14 **(8) INSURED'S RIGHT TO COMMENCE CIVIL PROCEEDING.** Nothing in this section
15 affects an insured's right to commence a civil proceeding relating to a matter that
16 may be appealed under the standards established under s. 636.12 (1).

17 **636.18 Rebate and report requirement.** Subject to s. 636.35, an insurer
18 offering small employer health insurance or individual health insurance coverage
19 shall comply with section 2718 of the Public Health Service Act (42 USC 300gg-18)
20 and shall file the report required under section 2718 (a) of that act (42 USC 300gg-18
21 (a)) with the commissioner no later than the date required for filing with the
22 secretary.

23 **636.25 Implementing health insurance coverage provisions.** Subject to
24 s. 636.35, notwithstanding any inconsistent provision in chs. 600 to 635 or chs. 644

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1 to 646, and unless the commissioner provides otherwise by rule under s. 636.10, all
2 of the following apply:

3 (1) **INSURERS.** An insurer shall comply with all of the following provisions of the
4 Public Health Service Act:

5 (a) *Standards relating to benefits for mothers and newborns.* Section 2725 (42
6 USC 300gg-25).

7 (b) *Required coverage for reconstructive surgery following mastectomies.*
8 Section 2727 (42 USC 300gg-27).

9 (c) *Coverage of dependent students on medically necessary leave of absence.*
10 Section 2728 (42 USC 300gg-28).

11 (d) *No lifetime limit or annual limits.* Section 2711 (42 USC 300gg-11).

12 (e) *Prohibition on rescissions.* Section 2712 (42 USC 300gg-12).

13 (f) *Prohibition on preexisting condition exclusions for under age 19.* Section
14 2704 (42 USC 300gg-04), but only for enrollees who are under 19 years of age.

15 (g) *Coverage of preventive health services.* Section 2713 (42 USC 300gg-13).

16 (h) *Extension of dependent coverage.* Section 2714 (42 USC 300gg-14).

17 (i) *Provision of additional information.* Section 2715A (42 USC 300gg-15a).

18 (j) *Patient protections; choice of health care professional.* Section 2719A (a) (42
19 USC 300gg-19a (a)).

20 (k) *Patient protections; coverage of emergency services.* Section 2719A (b) (42
21 USC 300gg-19a (b)). In addition, an insurer also shall comply with s. 632.85 and an
22 insurer that provides coverage under a defined network plan also shall comply with
23 s. 609.22 (6).

24 (2) **GRANDFATHERED HEALTH PLANS.** A grandfathered health plan shall comply
25 with all of the following provisions of the Public Health Service Act:

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1 (a) *Coverage of dependent students on medically necessary leave of absence.*

2 Section 2728 (42 USC 300gg-28).

3 (b) *Coverage of preventive health services.* Section 2713 (42 USC 300gg-13).

4 (c) *Patient protections; coverage of emergency services.* Section 2719A (b) (42
5 USC 300gg-19a (b)).

6 **(3) SELF-INSURED GOVERNMENTAL HEALTH PLANS.** A self-insured governmental
7 health plan shall comply with all of the following provisions of the Public Health
8 Service Act:

9 (a) *Coverage of dependent students on medically necessary leave of absence.*

10 Section 2728 (42 USC 300gg-28).

11 (b) *Extension of dependent coverage.* Section 2714 (42 USC 300gg-14).

12 (c) *Patient protections; coverage of emergency services.* Section 2719A (b) (42
13 USC 300gg-19a (b)). In addition, a self-insured governmental health plan also shall
14 comply with s. 632.85.

15 **(4) ADDITIONAL REQUIREMENTS.** With respect to health insurance coverage that
16 is issued or renewed on or after March 23, 2012, all of the following apply:

17 (a) *Insurers.* An insurer shall comply with all of the following provisions of the
18 Public Health Service Act:

19 1. 'Uniform explanation of coverage documents and standardization of
20 definitions.' Section 2715 (42 USC 300gg-15).

21 2. 'Ensuring the quality of care.' Section 2717 (42 USC 300gg-17).

22 (b) *Grandfathered health plans.* A grandfathered health plan shall comply
23 with section 2717 of the Public Health Service Act (42 USC 300gg-17), relating to
24 ensuring the quality of care.

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1 **(5) APPLICATION OF SECTION TO GRANDFATHERED HEALTH PLANS.** In addition to
2 subs. (2) and (4) (b), this section applies to a grandfathered health plan, but only with
3 respect to those provisions of the Public Health Service Act referred to in this section
4 that apply to a grandfathered health plan under section 1251 of the Patient
5 Protection and Affordable Care Act.

6 **636.35 Applicability if federal law found unconstitutional.** If the Patient
7 Protection and Affordable Care Act is found by a final decision of a federal court of
8 competent jurisdiction to be unconstitutional in its entirety and unenforceable in
9 this state, and if all appeals are exhausted or the time for appeal expires, insurers
10 and self-insured governmental health plans are exempt from all of the following
11 provisions on and after the first day of the 3rd month beginning after the date on
12 which all appeals are exhausted or the time for appeal expires:

13 **(1)** Section 625.13 (3).

14 **(2)** Section 636.18.

15 **(3)** Section 636.25, except for s. 636.25 (1) (h) and (3) (b).

16 **(4)** Chapter 625 with respect to small employer health insurance and group
17 and blanket accident and sickness insurance offered in the individual market.

18 **SECTION 44. Initial applicability.**

19 **(1) MISCELLANEOUS COVERAGE REQUIREMENTS.** The treatment of sections 40.51
20 (8) (by SECTION 2) and (8m) (by SECTION 4), 49.67 (3) (am) 2. b., 66.0137 (4) (by SECTION
21 7), 111.91 (2) (n) and (nm), 111.998 (2) (n), 120.13 (2) (g) (by SECTION 14), 185.983 (1)
22 (intro.) (by SECTION 16), 609.755, 632.76 (2) (ac) 1., 2., 3. (intro.), and 4., 632.885,
23 632.895 (15) (c) (intro.), and 636.25 (1), (2), (3), and (5) of the statutes first applies
24 to all of the following:

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1 (a) Except as provided in paragraphs (b), (c), and (d), disability insurance
2 policies that are newly issued, and self-insured governmental or school district
3 health plans that are newly established on the effective date of this paragraph.

4 (b) Except as provided in paragraph (d), disability insurance policies, and
5 self-insured governmental or school district health plans, that are grandfathered
6 health plans, as defined in section 636.01 (2) of the statutes, as created by this act,
7 that are renewed, extended, or modified on the effective date of this paragraph.

8 (c) Except as provided in paragraph (d), disability insurance policies, and
9 self-insured governmental or school district health plans, covering employees who
10 are affected by a collective bargaining agreement containing provisions inconsistent
11 with this act that are newly issued or newly established on the earlier of the
12 following:

13 1. The day on which the collective bargaining agreement expires.

14 2. The day on which the collective bargaining agreement is extended, modified,
15 or renewed.

16 (d) Disability insurance policies, and self-insured governmental or school
17 district health plans, that are grandfathered health plans, as defined in section
18 636.01 (2) of the statutes, as created by this act, that cover employees who are
19 affected by a collective bargaining agreement containing provisions inconsistent
20 with this act, and that are renewed, extended, or modified on the earlier of the
21 following:

22 1. The day on which the collective bargaining agreement expires.

23 2. The day on which the collective bargaining agreement is extended, modified,
24 or renewed.

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1 (2) INTERNAL AND EXTERNAL APPEALS. The treatment of sections 40.51 (8) (by
2 SECTION 1) (with respect to internal and external review procedures), 40.51 (8m) (by
3 SECTION 3) (with respect to internal and external review procedures), 66.0137 (4) (by
4 SECTION 6) (with respect to internal and external review procedures), 111.91 (2) (s),
5 111.998 (2) (s), 120.13 (2) (g) (by SECTION 13) (with respect to internal and external
6 review procedures), 185.983 (1) (intro.) (by SECTION 15) (with respect to internal and
7 external review procedures), 600.01 (2) (b), 609.655 (4) (b), 632.83, 632.835, 636.12,
8 and 636.15 of the statutes first applies to appeals filed on the effective date of this
9 subsection.

10 **SECTION 45. Effective dates.** This act takes effect on the day after publication,
11 except as follows:

12 (1) HEALTH INSURANCE COVERAGE PROVISIONS. The treatment of sections 40.51 (8)
13 (by SECTION 2) and (8m) (by SECTION 4), 49.67 (3) (am) 2. b., 66.0137 (4) (by SECTION
14 7), 111.91 (2) (n) and (nm), 111.998 (2) (n), 120.13 (2) (g) (by SECTION 14), 185.983 (1)
15 (intro.) (by SECTION 16), 609.755, 632.76 (2) (ac) 1., 2., 3. (intro.), and 4., 632.885,
16 632.895 (15) (c) (intro.), 636.25, and 636.35 of the statutes and SECTION 44 (1) of this
17 act take effect on the first day of the 6th month beginning after publication.

18 (2) INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE RATING. The treatment of
19 sections 601.465 (1m) (d), 625.02 (1), (1h), (1p), (2f), and (2s), 625.13 (1) and (3), and
20 625.14 of the statutes, the renumbering and amendment of section 625.03 (1m) (e)
21 of the statutes, and the creation of section 625.03 (1m) (e) 2. and 3. of the statutes take
22 effect on September 1, 2011, or on the day after publication, whichever is later.

23 **(END)**