



2007 ASSEMBLY BILL 871

February 25, 2008 - Introduced by Representatives VUKMIR, F. LASEE, NYGREN, KRAMER, MOULTON, ZIPPERER, VOS, LOTHIAN, PETERSEN, BIES, ALBERS, A. OTT, LEMAHIEU, NEWCOMER, PRIDEMORE and M. WILLIAMS, cosponsored by Senators A. LASEE and DARLING. Referred to Committee on Health and Healthcare Reform.

1 **AN ACT to create** 632.845 of the statutes; **relating to:** health insurance without
2 mandated benefits, providing an exemption from emergency rule procedures,
3 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.

This bill authorizes an insurer to offer single or family health insurance coverage in individual policies that do not include any or 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 certain specified providers whose services may not be excluded under current law. To be eligible for coverage that does not include any or all of the mandates, a person must be under 36 years old, have family income below 300 percent of the poverty line, or be eligible for continuation coverage. A person whose employer does not offer group health care coverage is also eligible.

ASSEMBLY BILL 871

Under the bill, 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.

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

1 **SECTION 1.** 632.845 of the statutes is created to read:

2 **632.845 Health care coverage without mandates. (1) DEFINITIONS.** In this
3 section:

4 (a) “Disability insurance policy” has the meaning given in s. 632.895 (1) (a).

5 (b) “Family income” means the total gross earned and unearned income
6 received by all members of a family.

7 (c) “Federal continuation provision” has the meaning given in s. 632.745 (8).

8 (d) “Health care provider” has the meaning given in s. 146.81 (1).

9 (e) “Insurer” means an insurer that is authorized to do business in this state
10 in one or more lines of insurance that includes health insurance.

11 (f) “Mandate” means a health insurance mandate, as defined in s. 601.423 (1).

12 (g) “Poverty line” means the poverty line as defined and revised annually under
13 42 USC 9902 (2).

ASSEMBLY BILL 871

1 **(2) AUTHORITY TO OFFER; ELIGIBILITY; COVERAGE.** (a) Except as provided in par.
2 (d), notwithstanding any other provisions of chs. 600 to 646 to the contrary, an
3 insurer may offer and provide individual disability insurance policies that do not
4 include any or all of the mandates. The policies may provide single or family
5 coverage, or both. The coverage must be offered in accordance with this section.

6 (b) An individual and his or her dependents are eligible for coverage described
7 in par. (a) if the individual satisfies any of the following criteria:

8 1. The individual is under 36 years of age.

9 2. The individual has a family income that is less than 300 percent of the
10 poverty line.

11 3. The individual's employer does not offer group health care coverage.

12 4. The individual is eligible for continuation coverage under a federal
13 continuation provision or similar state program.

14 (c) 1. An individual who claims eligibility for coverage under par (b) 3. may
15 satisfy that requirement by signing a statement to the effect that his or her employer
16 does not offer group health care coverage.

17 2. An individual who is eligible for coverage under par. (b) 4. may be covered
18 under the coverage under this section for no longer than 18 months.

19 (d) An insurer may not refuse to provide or pay for benefits under a disability
20 insurance policy under this section for health care services provided by a health care
21 provider on the ground that the services were not rendered by a physician, as defined
22 in s. 990.01 (28), unless the policy clearly excludes services by such health care
23 providers, but no policy under this section may exclude services in violation of s.
24 632.87 (2), (2m), (3), (4), or (5).

ASSEMBLY BILL 871**SECTION 1**

1 **(3) FORM, INFORMATION, AND CHOICE REQUIREMENTS.** (a) An insurer that offers
2 coverage described in sub. (2) (a) shall allow an individual applying for coverage to
3 choose to have the coverage include none, one or more, or all of the mandates. The
4 application shall include a separate form that provides a plain-language
5 explanation of the differences between the coverage being offered and health care
6 coverage that is subject to all of the mandates. The separate form also shall provide,
7 in list form, a plain-language description of each mandate and all of the following
8 information about each mandate:

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

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

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

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

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

22 (c) 1. Each mandate on the separate form under par. (a) or (b) listing the
23 mandates shall be followed by a line on which the individual must indicate “yes” or
24 “no” as to whether the mandate should be included in the coverage. The form shall

ASSEMBLY BILL 871

1 include a line for the signature of the applicant or insured and shall be a part of the
2 signed application or renewal form.

3 2. If an individual fails to timely return a form that was sent with a renewal
4 notice, or timely returns the form but fails to indicate on the form a “yes” or “no” as
5 to whether a mandate should be included in the coverage, the failure constitutes an
6 agreement to continue the coverage on its existing terms without the mandate.

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

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

15 **SECTION 2. Nonstatutory provisions.**

16 (1) EMERGENCY RULES. Using the procedure under section 227.24 of the statutes,
17 the commissioner of insurance may promulgate rules required under section 632.845
18 (4) of the statutes, as created by this act, for the period before the effective date of the
19 permanent rules promulgated under section 632.845 (4) of the statutes, as created
20 by this act, but not to exceed the period authorized under section 227.24 (1) (c) and
21 (2) of the statutes. Notwithstanding section 227.24 (1) (a), (2) (b), and (3) of the
22 statutes, the commissioner is not required to provide evidence that promulgating a
23 rule under this subsection as an emergency rule is necessary for the preservation of
24 the public peace, health, safety, or welfare and is not required to provide a finding
25 of emergency for a rule promulgated under this subsection.

