Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873

May 19, 2009 Joint Committee on Finance Paper #482

Health Insurance Provisions (Insurance)

[LFB 2009-11 Budget Summary: Page 417, #11 through #16]

CURRENT LAW

Coverage Requirement for Dependents. Several provisions in current law relate to health insurance coverage of dependents of an insured. However, there is no requirement for health insurance policies to cover dependents up to a specified age. The provisions in current law include the following:

- All health insurance policies must cover a newly born child of an insured, from the moment of birth. If the insured does not notify the insurer of the birth within 60 days and does not pay any necessary premiums for coverage of the child, the insurer may discontinue coverage of the child.

- If a health insurance policy covers dependents, it must cover the child of any dependent, if that dependent is under 18 years of age.

- If a health insurance policy covers dependent children who are full-time students, that policy must continue to cover a dependent if he or she ceases to be a full-time student due to a medically necessary leave of absence.

- If a health insurance policy covers dependent children up to a certain age, the policy may not cease coverage of a dependent at the specified age if the child is incapable of self-sustaining employment because of mental retardation or physical handicap, and is chiefly dependent upon the person insured under the policy for support and maintenance.

Independent Review of Coverage Denial Determinations and Rescissions. Current law allows for independent review of certain decisions by an insurer to not provide coverage or payment for treatment, to be conducted by organizations certified by the Office of the Commissioner of Insurance (OCI). These decisions subject to independent review are the

following: (a) adverse determinations, where a provided benefit was determined to not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; and (b) experimental treatment determinations, where a proposed treatment was denied on the grounds that is was experimental. Independent review takes place after an insurer's internal grievance procedures have been exhausted. An insured must pay a $25 fee for requesting an independent review, which is refunded if the insurer's decision is overturned.

Renewal of Individual Health Insurance Policies. Insurers who issue individual health insurance policies must renew these policies if the insured wishes to do so, with certain exceptions. Upon renewal of the policy, the insurer may modify the policy form, as long as the modifications are consistent with state law and effective for all individuals covered under that policy form.

Preexisting Condition Exclusions for Individual Health Insurance Policies. Current law provides that an individual health insurance policy may deny coverage for a preexisting condition for up to two years after the date the policy was issued. "Preexisting condition" is not defined in current law for the purposes of an individual insurance policy, and there is no statutory limit to the amount of time an insurer may "look back" for the existence of a preexisting condition.

GOVERNOR

Coverage Requirement for Dependents (Page 417, #11 in the LFB 2009-11 Budget Summary). Require every health insurance policy, and every self-insured health plan of the state or county, city, town, village, or school district that provides coverage for a person as a dependent of an insured to provide dependent coverage for a child of an insured unless: (a) the child is 27 years of age or older; (b) the child is married; (c) the child has other health care coverage; (d) the child is employed full time and his or her employer offers health care coverage to its employees; or (e) coverage of the insured through whom the child has dependent coverage under the policy or plan is discontinued or not renewed.

The new requirements would take effect on the first day of the seventh month beginning after the bill's publication. However, the requirements would first apply to: (a) health policies that are issued or renewed, and governmental or school district self-insured health plans that are established, extended, modified, or renewed, on that date; (b) health policies covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with these requirements that are issued or renewed on the earlier of the day on which the collective bargaining agreement expires, or the day on which the collective bargaining agreement is extended, modified, or renewed (after the effective date); and (c) governmental or school district self-insured plans covering employees who are affected by a collective bargaining agreement containing provisions that are inconsistent with these requirements that are established, extended, modified, or renewed on the earlier of the day on which the bargaining agreement expires or the day on which the collective bargaining agreement is extended, modified, or renewed.

Independent Review of Coverage Denial Determinations and Rescissions (Page 417, #12). Modify current provisions relating to the types of adverse decisions that are eligible for review under a group or individual health benefit plan's independent review procedure to include the following: (a) the rescission of a policy or certificate; and (b) a coverage denial determination based on a preexisting condition exclusion. Define a "preexisting condition exclusion denial determination" as a determination by, or on behalf of, an insurer that issues a health benefit plan denying or terminating treatment or payment for treatment on the basis of a preexisting condition exclusion.

Require the Commissioner to make a determination that at least one independent review organization (IRO) has been certified that is able to effectively provide the independent review required for preexisting condition exclusion denial determinations and rescissions, and publish a notice in the Wisconsin Administrative Register that states a date that is two months after the Commissioner makes the determination. The date in the notice would be the date on which the independent review procedure begins operating with respect to preexisting condition exclusion denial determinations and rescissions. Require that the independent review relating to preexisting condition exclusion denial determinations and rescissions be available to an insured who receives notice of the disposition of his or her grievance on or after the date stated in the notice.

Specify that the independent review procedures would not affect an insured's right to commence a civil proceeding relating to a coverage denial determination. Further, specify that a decision of an IRO regarding a preexisting condition exclusion denial determination or a rescission is not binding on the insured.

Repeal a provision that requires an insured or his or her authorized representative to pay a $25 fee to the independent review organization, which is refunded by the insurer if the insured prevails on the review.

Modification at Renewal of Individual Health Insurance Policy (Page 418 #13). Require an insurer that issues an individual major medical or comprehensive health benefit plan, at the time of a coverage renewal and at the request of an insured, to permit the insured to either: (a) modify his or her existing coverage by electing an optional higher deductible, if any, under the individual major medical or comprehensive health benefit plan; or (b) change his or her coverage to any of the following:

- a different but comparable individual major medical or comprehensive health benefit plan currently offered by the insurer;

- an individual major medical or comprehensive health benefit plan currently offered by the insurer with more limited benefits; or

- an individual major medical or comprehensive health benefit plan currently offered by the insurer with higher deductibles.

Prohibit an insurer from imposing any new preexisting condition exclusions under the new or modified coverage that did not apply to the insured's original coverage, and require the insurer to allow the insured credit under the new or modified coverage for the period of original coverage. For any new or modified coverage, prohibit an insurer from rating for health status

other than on the insured's health status at the time the insured applied for the original coverage and as the insured disclosed on the original application.

Require each insurer to mail to each insured under an individual major medical or comprehensive health benefit plan issued by the insurer, a notice that includes all of the following: (a) that the insured has the right to elect alternative coverage as described above; (b) a description of the alternatives available to the insured; and (c) the procedure for making the election. Require insurers to send his notice not more than three months or less than 60 days before the renewal date of the insured's plan.

Provide that these provisions would not require an insurer to issue alternative coverage if the insured's coverage may be nonrenewed or discontinued, as provided by law. In addition, specify that these provisions would apply to a group health benefit plan if that plan is an individual major medical or comprehensive health benefit plan, which the bill would define as coverage under a group health benefit plan that is underwritten on an individual basis and issued to individuals or families.

These provisions would first apply to individual major medical or comprehensive health benefit plans that are renewed on the bill's general effective date.

Preexisting Condition Exclusions for an Individual Health Insurance Policy (Page 419, #14). Permit insurers to deny claims for loss incurred or disability for up to one year from the date of issue of the policy on the ground that the disease or physical condition existed prior to the effective date of the coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of loss.

Prohibit an individual health insurance policy from defining a preexisting condition more restrictively than a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within 12 months before the effective date of coverage.

Provide that these provisions would first apply to individual health insurance policies that are issued or renewed on the bill's general effective date.

Individual Health Policy Uniform Application (Page 419 #15). Require the Commissioner of Insurance, by rule, to prescribe uniform questions and the format for applications, not to exceed 10 pages, for individual major medical health insurance policies, including health care coverage provided on an individual basis through an association.

Require the Commissioner to submit proposed rules to the Legislative Council staff no later than the first day of the 12th month beginning after the bill's general effective date. Provide that, after the effective date of the rules, insurers could use only the prescribed questions and format for individual major medical health insurance policy applications. Require the Commissioner to publish a notice in the Wisconsin Administrative Register that states the effective date of the proposed rules.

Cancellation and Rescission Reports (Page 420, #16). Beginning in 2009, require every insurer that issues individual health insurance policies to report annually to the Commissioner of

Insurance the total number of individual health insurance policies that the insurer issued in the preceding year and the total number of individual health insurance policies for which the insurer initiated or completed a cancellation or rescission in the preceding year.

DISCUSSION POINTS

1. Separate legislation has been introduced in each house of the Legislature that would implement similar policies to those proposed in AB 75. While the provisions of the budget bill and the stand-alone bills are similar, there are some differences. The attachment to this paper provides a comparison of the provisions of 2009 Senate Bills 70, 71 and 72 (2009 Assembly Bills 100, 108 and 118) as introduced, and the health insurance provisions in AB 75.

2. AB 100, as amended by Assembly Amendment 1, has been passed by the Assembly, and has been referred to the Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue. As amended, Engrossed AB 100 differs from the provisions in AB 75. AB 108 is currently in the Assembly Committee on Health and Healthcare Reform, and AB 118 is currently in the Assembly Committee on Insurance.

3. Senate Bills 70, 71, and 72 are currently in the Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue. No executive action has been taken, but a public hearing was held for these bills on April 22, 2009.

4. It should be noted that while the provisions of the stand alone bills are similar to the provisions of the budget, they are not identical. If the budget bill is passed with these provisions and the Legislature acts on one of the stand alone bills, the language would be merged, if there were no conflicts with the bills. However, if two bill are passed that conflict and therefore cannot be merged, both pieces of legislation would stand, until an additional bill is passed to address any conflict or contradiction.

5. The mandate for coverage of dependents up to the age of 27 would only apply to private insurance plans and self-insured governmental plans. This mandate would not apply to self-insured benefit plans offered by private employers, which are governed by provisions of the federal Employee Retirement Income Security Act of 1974 (ERISA) and not subject to state regulation. In 2007, OCI estimated that 38% of the state's population was covered by self-insured employer plans (and therefore, would not be subject to the mandate), and 28% of the population was insured under a commercial insurance product (and therefore, would be subject to this mandate).

6. The National Conference of State Legislatures estimates of the national percentage of adults ages 19 to 29 who are uninsured equals approximately 30%. Estimates for Wisconsin place the state's uninsured rate among this age group at approximately 17%.

7. SB 70 and AB 118 would implement a similar coverage requirement for adult children to that included in the budget bill, with several differences:

a. The budget bill and the stand alone bills establish different criteria for an unmarried adult child under the age of 27 to be eligible to receive coverage under a parent's plan. Under the budget bill, an adult child would be eligible if he or she does not have other health care coverage,

and is not a full time employee for an employer who offers health coverage; under the stand alone bills, an adult child would be eligible if he or she is not eligible for employer-based coverage with premiums less than those premiums for dependent coverage under the parent's insurance plan.

b. The stand alone bills would include the following provisions that are not included in the budget bill: (a) provide coverage for adult children only if the parent requests that dependent coverage be provided; (b) provide coverage for an adult child whose full-time student status was interrupted by an active tour of duty in the armed forces, and returns to full-time student status, regardless of age; (c) require the insurer to determine the premium for coverage of a dependent over 18 years old on the same basis as the insurer determines the premium for coverage of a dependent who is 18 years old or younger; and (d) allow an insurer to require that an applicant or insured seeking coverage for a dependent child provide written documentation that the child satisfies the criteria for coverage under the bill.

8. The Department of Employee Trust Funds submitted a fiscal estimate with the introduction of SB 70, with the Group Insurance Board's consulting actuary estimating that the cost of this mandate would be approximately 1% of premium costs. This would result in additional annual costs of approximately $10.0 million for the state employee coverage plans, and costs of between $1.5 million and $1.8 million for local government plans offered by the Group Insurance Board. The budget bill would not provide funding to support these anticipated costs. Any additional state agency costs would be covered through pay plan supplements funded from state compensation reserves, or agency budgets, if needed.

9. The independent review process allows independent medical professionals to review certain decisions made by an insurer. Currently only decisions regarding experimental treatments and adverse determinations concerning medical necessity, appropriateness, health care setting, level of care, or effectiveness may be brought to an independent review organization (IRO). In calendar year 2008, six certified IROs received a total of 110 requests for review. Of these, the decision of the insurer was upheld in 64 cases, the decision was overturned in 36 cases, and the IRO declined the request for review in the remaining 10 cases.

10. Under current law, the insured individual must pay a $25 fee to the IRO, which would be refunded if the IRO overturns the insurer's decision. The budget bill eliminates this $25 fee, but the stand alone legislation (SB 71/AB 108) would maintain this fee.

11. The individual insurance market represented approximately 9% of the commercial health insurance market in 2007, with a total of 145,084 individuals covered by these policies. This percentage has fluctuated since the mid-1990s, ranging from 5% to 15% of the commercial health insurance market.

12. Current law allows individual insurance policies to contain a preexisting condition exclusion period of up to two years (group policies may have a preexisting condition exclusion period of up to one year). The bill would lower the maximum allowable preexisting waiting period for an individual insurance policy to 12 months. There is no statutory restriction on the period of time an insurer is allowed to consider when determining whether an insured had a preexisting condition (a "look-back" period). The bill would establish a maximum look-back period for preexisting conditions of 12 months, for individual insurance policies.

13. Additionally, there is no statutory definition of a "preexisting condition." This allows insurers to apply a "prudent person" standard, defining a preexisting condition as a condition for which an ordinary person would have attempted to seek medical attention or care. The bill would implement an "objective standard," requiring individual insurance policies to define a preexisting condition no more restrictively than a condition for which medical advice, diagnosis, care or treatment was recommended or received within the look-back period.

14. In 2008, 24 states applied the "prudent person" standard, and 18 applied the "objective person" standard. The following table provides a comparison of the definition of a preexisting condition, the maximum look-back period, and the maximum preexisting exclusion period, for selected states.

Requirements of Preexisting Condition Exclusion for Individual Insurance Policies
Selected States, 2008

	Definition of Preexisting Condition	Maximum Look-Back Period (in Months)	Maximum Exclusion Period (in Months)
Illinois	Prudent Person and Objective	24	24
Indiana	Prudent Person	12	12
Iowa	Prudent Person	60	24
Michigan	Objective	6	12
Minnesota	Objective	6	18
Ohio	Prudent Person	6	12
Wisconsin (Current)	Prudent Person	No Limit	24
Wisconsin (Proposed)	Objective	12	12

Source: Kaiser Family Foundation State Health Facts

15. If the Committee wished to do so, it could approve certain groups of provisions proposed in the Governor's budget bill (Alternative 2). This would allow the standing committees of the Legislature to act on the other provisions contained in Senate Bills 70, 71, and 72, and Assembly Bills 100, 108, and 118. Alternative 2 provides options to approve any of the separate health insurance items, organized by the provisions in the bills that have been introduced in the Legislature. The options are not mutually exclusive -- the Committee may adopt any number of these options.

ALTERNATIVES

1. Approve the Governor's recommendations.

2. Delete the following groups of proposals from the bill:

a. Delete the provisions relating to mandated coverage of unmarried dependents up to the age of 27 (page 417, #11 in the LFB 2009-11 Budget Summary). These provisions correspond with SB 70 and AB 118.

b. Delete the provisions relating to individual insurance policies and the following items: (a) preexisting condition exclusions (page 419, #14); (b) modifications at renewal (page 418, #13); and (c) the development of a uniform application (page 419, #15). These provisions correspond with SB 71 and AB 100.

c. Delete the provisions relating to the including preexisting condition exclusion determination and policy rescissions in the decisions that may be submitted for independent review, and the requirement that insurers annually report the number of individual insurance policies that have been cancelled or rescinded (page 417, #12, and page 420, #16). These provisions correspond with SB 72 and AB 108.

3. Delete the provisions.

Prepared by: Sam Austin
Attachments

ATTACHMENT

SB 70 and AB 118
Coverage of Dependents

SB 70/AB 118	Budget Bill
If the policy provides coverage for dependents, provide coverage for an adult child who meet these criteria: (a) is not married; (b) is under 27 years of age; and (c) is not eligible for employer-based coverage with premiums less than those premiums for dependent coverage under the parent's insurance plan.	If the policy provides coverage for dependents, provide coverage for a child of an insured who meets these criteria: (a) is not married; (b) is under 27 years of age; (c) does not have other health care coverage; and (d) is not a full time employee for an employer who offers health coverage. This coverage need not be provided for a policy or plan that is discontinued or non-renewed.
Provide coverage to adult children only if the parent requests that dependent coverage be provided.	No additional language.
Provide coverage for an adult child whose full-time student status was interrupted by an active tour of duty in the armed forces, and returns to full-time student status, regardless of age.	
Require the insurer to determine the premium for coverage of a dependent over 18 years old on the same basis as the insurer determines the premium for coverage of a dependent who is 18 years old or younger.	
Allow an insurer to require that an applicant or insured seeking coverage for a dependent child provide written documentation that child satisfies the criteria for coverage under the bill.	

ATTACHMENT (continued)

SB 71 and AB 100

Individual Insurance Policies: Pre-existing Condition Exclusions, Modifications at Renewal, and Uniform Application

SB 71/AB 100	Budget Bill
Limit the length of an allowable pre-existing condition exclusion for an individual insurance policy to a maximum of 12 months.	Limit the length of an allowable pre-existing condition exclusion for an individual insurance policy to a maximum of 12 months.
Provide that an individual insurance policy may define a "pre-existing condition" no 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 the coverage.	Provide that an individual insurance policy may define a "pre-existing condition" no more restrictively than a condition for which medical advice was given, or treatment was recommended or received within 12 months before the effective date of the coverage.
Require an insurer to modify an individual insurance policy upon renewal in any of the following ways: (a) modify the benefits or deductible level; and (b) provide coverage under a different but comparable individual insurance policy, with no additional underwriting.	Require an insurer to modify an individual insurance policy upon renewal in any of the following ways: (a) modify existing coverage to include a higher deductible; (b) provide a different but comparable individual insurance policy; (c) provide an individual insurance policy with more limited benefits; or (d) provide an individual insurance policy with higher deductibles.
Require the Commissioner of Insurance to prescribe uniform questions and a uniform format for an application for an individual insurance policy. Require insurers to use this uniform application, which would not exceed 10 pages.	Require the Commissioner of Insurance to prescribe uniform questions and a uniform format for an application for an individual insurance policy. Require insurers to use this uniform application, which would not exceed 10 pages.
Amendment to AB 100 (AB 100, as amended, was passed by the Assembly on April 28, 2009)	
Exempt short-term polices from renewal requirements, and the 12 month maximum pre-existing exclusion period.	
Apply the same definition of pre-existing condition for short-term policies as is applied to individual insurance policies.	
Require short-term polices to reduce pre-existing condition exclusion periods by the period of creditable coverage.	
Remove reference to "physician" in definition of pre-existing condition.	
Make other technical changes to the bill.	

ATTACHMENT (continued)

SB 72 and AB 108

Independent Review of Pre-existing Conditions and Rescissions, Reports to OCI on Cancellation and Rescissions

SB 72/AB 108	Budget Bill
Include a pre-existing condition and a policy rescission in the insurer decisions that may be taken to an independent review organization	Include a pre-existing condition and a policy rescission in the insurer decisions that may be taken to an independent review organization
Require every insurer that sells individual insurance policies to submit an annual report to OCI on the number of policies that have been rescinded or cancelled, or where a cancellation or rescission has been initiated, over the previous year.	Require every insurer that sells individual insurance policies to submit an annual report to OCI on the number of policies that have been rescinded or cancelled, or where a cancellation or rescission has been initiated, over the previous year.
Increase the allowable "gap" between coverage periods from 63 to 90 days, for the purposes of counting creditable coverage for implementing a pre-existing condition exclusion.	No language concerning allowable "gap" between coverage periods.