

# **Wisconsin Health Insurance Law Changes**

**Section 601.41** concerns the use of a uniform application for individual health insurance and contains the following provisions:

1. OCI is required by rule to prescribe uniform questions and the format for applications which may not exceed 10 pages in length for individual major medical health insurance policies;
2. After the effective date of the rules promulgated by the office, an insurer may only use the prescribed questions and format; and
3. For the uniform application requirements, an individual major medical policy includes health coverage provided on an individual basis through an association.

**Section 601.428** requires, beginning in 2009, every insurer that issues individual health insurance policies to annually report to the office the total number of individual health insurance policies issued in the preceding year and the total number of individual health insurance policies with respect to which the insurer initiated or completed a cancellation or rescission in the preceding year. OCI will prescribe a reporting form.

**Section 609.655** requires defined network plans to include a licensed mental health professional as defined in s. 632.89 (1) (e) 2, 3, or 4 in covering the clinical assessment of a dependent student's nervous or mental disorder or alcoholism or other drug abuse.

**Section 632.7495 (4)** concerning the renewability of individual health insurance policies designed to provide short-term coverage as bridge coverage is amended. An insurer is not required to renew a bridge policy so long as:

1. The coverage is marketed and designed to provide short-term coverage as a bridge between coverage periods;
2. The coverage has a term of not more than 12 months; and
3. The coverage term aggregated with all consecutive periods of the insurer's coverage of the insured by individual health benefit plan coverage not required to be renewed does not exceed 18 months. Coverage periods are consecutive if there are no more than 63 days between the coverage periods.

The Commissioner is required to promulgate rules governing the disclosures related to, and may promulgate rules setting standards for, the sale of these products.

The above provisions take effect for those policies issued or renewed on or after January 1, 2010.

**Section 632.7497** concerning policyholder or certificate holder rights under an individual major medical policy or comprehensive health benefit plan, including a group policy that is underwritten on an individual basis, includes the following provisions:

1. At the time of renewal and at the request of an insured, an insurer must permit the insured to do either of the following:

- a. Change the coverage to
    - i. A different but comparable individual major medical or comprehensive health benefit plan currently offered by the insurer;
    - ii. An individual major medical or comprehensive health benefit plan offered by the insurer with more limited benefits; or
    - iii. An individual major medical or comprehensive health benefit plan offered by the insurer with higher deductibles.
  - b. Modify the existing coverage by electing an optional higher deductible, if any, under the individual major medical or comprehensive health benefit plan.
2. The insurer may not impose new preexisting condition exclusions under the new or modified coverage selected by the insured that did not apply to the original coverage and shall allow credit under the new or modified coverage for the period of original coverage.
  3. The insurer may not rate for health status for the new or modified coverage other than the insured's health status at the time the insured applied for original coverage and as disclosed on the original application.
  4. Annually, insurers shall mail, not more than 3 months nor less than 60 days before the renewal date, to each insured under an individual major medical or comprehensive health benefit plan a notice containing the following:
    - a. The right to elect alternative coverage;
    - b. A description of the alternative coverage(s) available; and
    - c. The process for making the election.
  5. Insurers are not required to offer alternative coverage if the individual major medical or comprehensive health benefit plan are cancelled or nonrenewed for the reasons contained in s. 632.7495 (2), (3) (b), or (4).
  6. Notwithstanding the provisions of s. 600.01 (1) (b) 3 and 4, the above applies to group health benefit plans if the group health benefit plans are individual major medical or comprehensive health benefit plans as defined in this section.

The provisions of this section first apply to individual major medical and comprehensive health benefit plans that are renewed on or after January 1, 2010.

For short-term plans, the treatment of s. 632.7495 (5), the renumbering and amendments to s. 632.7495 (4), and the creation of s. 632.7495 (4) (b), (c), and (d) first apply to individual health benefit plans that are short-term plans and that are issued or renewed on or after January 1, 2010.

**Section 632.76 (2) (ac)** concerning preexisting condition limitations for individual disability insurance coverage includes the following:

1. No claim incurred after 12 months from the date of issue of an individual disability insurance policy as defined in s. 632.895 (1) (a) may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of the loss.
2. An individual disability insurance policy as defined in s. 632.895 (1) (a), other than a short-term policy subject to s. 632.7495 (4) and (5), may not define 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.

3. All of the following apply to short-term disability insurance policies subject to s. 632.7495 (4) and (5):
  - a. A short-term individual disability insurance policy may not define 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 before the effective date of the coverage;
  - b. The policy shall reduce the length of time during which a preexisting condition exclusion may be imposed by the aggregate of the insured's consecutive periods of coverage under the insurer's individual short-term disability policies. Coverage periods are consecutive if there are no more than 63 days between the coverage periods.

The above provisions take effect for those policies issued or renewed on or after January 1, 2010.

**Section 632.835** concerning independent review of adverse insurer findings has been expanded to include coverage denial determinations, including preexisting condition exclusion denial determinations and rescissions of a policy or certificate, and contains the following new statutory provisions:

1. New definitions are included in the section:
  - a. "Coverage denial determination" means an adverse determination, an experimental treatment determination, a preexisting condition exclusion denial determination, or a rescission of a policy or certificate.
  - b. "Preexisting condition exclusion denial determination" means 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 as defined in the statutes.
2. The statute affirmatively states that nothing in the section affects an insured's right to commence a civil proceeding relating to a coverage denial determination [s. 632.835 (2) (e)].
3. The \$25 required fee of the person requesting the independent review has been eliminated [s. 632.835 (3) (a)].
4. The statute states that the decision of the independent review organization regarding a preexisting condition exclusion denial determination or a rescission is not binding on the insured [s. 632.835 (3) (f) 2].
5. OCI must make a determination that at least one independent review organization has been certified by the office to effectively provide independent reviews for preexisting condition exclusion denial determinations and rescissions and must publish a notice in the Wisconsin Administrative Register that states a date that is 2 months after the office makes the determination. The date contained in the notice is the date on which the independent review procedure begins operating with respect to preexisting condition exclusion denial determinations and rescissions [s. 632.835 (8) (b)].

6. The independent review concerning preexisting condition exclusion denial determinations and rescissions is available to an insured who receives an adverse notice of the disposition of his or her internal grievance [s. 632.835 (9) (b)].

The above provisions take effect on July 1, 2009.

**Section 632.845** prohibits an insurer that provides coverage under a health care plan, as defined in s. 628.36 (2), to refuse to cover health care services that are provided to an insured under the plan and for which there is coverage under the plan on the basis that there may be coverage for such services under a liability insurance policy.

The above provision takes effect on November 1, 2009.

**Section 632.885** concerns coverage of dependents. It applies to disability insurance policies as defined in s. 632.895 (1) (a) and self-insured health plans of the state or of a county, city, village, town, or school district, along with limited service health organizations, preferred provider plans and defined network plans. It contains the following provisions:

1. Insurers that offer disability insurance policies and self-insured health plans are required to offer, and if requested by an applicant or insured, coverage for an adult child of the applicant or insured as a dependent of the applicant or insured if the child satisfies all of the following:
  - a. The child is over 17 but less than 27 years of age;
  - b. The child is not married; and
  - c. The child is not eligible for coverage under a group health benefit plan that is offered by the child's employer and for which the amount of the child's premium contribution is no greater than the premium amount for his or her coverage as a dependent under the parent's plan.
2. Notwithstanding the above requirements, the coverage requirements apply to an adult child who satisfies all of the following:
  - a. The child is a full-time student, regardless of age;
  - b. The child is not married and the child is not eligible for coverage under a group health benefit plan that is offered by the child's employer and for which the amount of the child's premium contribution is no greater than the premium amount for his or her coverage as a dependent under the parent's plan; and
  - c. The child was under 27 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education.
3. An insurer or self-insured plan is required to determine the premium for coverage of a child who is over 18 on the same basis as the premium is determined for a dependent who is 18 years of age or younger.
4. An insurer or self-insured health plan may require documentation from an applicant or an insured seeking coverage of a dependent child initially and annually thereafter that the child meets the criteria for coverage under this provision.

The above provisions take effect on January 1, 2010

**Section 632.89 (1dm)** adds the definition of licensed mental health professional to mean a clinical social worker who is licensed under ch. 457, a marriage and family therapist who is licensed under s. 457.10, or a professional counselor who is licensed under s. 457.12.

**Section 632.89 (1) (e) 3** is repealed and recreated to read a psychologist licensed under ch. 455.

**Section 632.89 (1) (e) 4** is created to read a licensed mental health professional practicing within the scope of his or license under ch. 457 and applicable rules.

The above provisions apply to policies issued or renewed on or after July 1, 2009.

**Section 632.895 (12m)** requires coverage for the treatment of autism spectrum disorders. Following are major provisions of the statute. OCI will promulgate an administrative rule interpreting and implementing certain provisions of the statute.

1. Autism spectrum disorder means any of the following:
  - a. Autism disorder;
  - b. Asperger's syndrome; or
  - c. Pervasive developmental disorder not otherwise specified.
2. This requirement applies to every disability insurance policy and self-insured health plan of the state, county, city, town, village, or school district. It also applies to defined network plans as contained in s. 609.87. It does not apply to:
  - a. A disability policy that covers only certain specified diseases;
  - b. A health care plan offered by a limited service health organization or by a preferred provider plan that is not a defined network plan;
  - c. A long-term care insurance policy; or
  - d. A Medicare replacement or a Medicare supplement policy.
3. The coverage required shall provide at least \$50,000 for intensive-level services per insured per year, with a minimum of 30 to 35 hours of care per week for a minimum duration of 4 years, and at least \$25,000 for nonintensive-level services per insured per year, except that these minimum coverage monetary amounts shall be adjusted annually, beginning in 2011, to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical group, as determined by the U.S. Department of Labor.
4. The coverage may be subject to deductibles, coinsurance, or co-payments that generally apply to other conditions covered by the policy or plan. The coverage may not be subject to limitations or exclusions, including limitations on the number of treatment visits.

The above provisions apply to policies issued or renewed on or after November 1, 2009.

**Section 632.895 (15)**, coverage of student on medical leave, has been amended so that the provisions contained in newly created s. 632.885, coverage for dependents, are extended to coverage for students on medical leave.

**Section 632.895 (17)** was created to require coverage for contraceptives and services in all disability insurance policies and self-insured health plans of the state or of a county, city, town,

village, or school district, that provide coverage for outpatient health care services, preventive treatments and services, or prescription drugs and devices, including limited service health organizations, preferred provider plans and defined network plans, as follows:

1. Coverage for contraceptives prescribed by a health care provider;
2. Coverage for outpatient consultations, examinations, procedures, and medical services, if covered for any other drug benefits under the policy or plan;
3. Coverage may only be subject to the exclusions, limitations, and cost-sharing provisions that apply generally to the applicable coverage under the policy or plan;
4. This requirement does not apply to:
  - a. A disability policy that covers only certain specified diseases;
  - b. A health care plan offered by a limited service health organization or by a preferred provider plan that is not a defined network plan;
  - c. A long-term care insurance policy; or
  - d. A Medicare replacement or a Medicare supplement policy.

The above provisions take effect on January 1, 2010.

As stated earlier, this is a summary of most of the provisions contained in Act 28 affecting insurance. You are strongly advised to review the actual language in determining how the new provisions in the Act affect you or your company.

Unless otherwise noted, the newly enacted provisions take effect on the first day beginning after publication of this Act.

Taken from the *State of Wisconsin* Office of the Commissioner of Insurance website.

File link: <http://oci.wi.gov/bulletin/0709act28.htm>