State of Wisconsin
2011 − 2012 LEGISLATURE

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ASSEMBLY SUBSTITUTE AMENDMENT ,

TO 2011 ASSEMBLY BILL 210

AN ACT ***to repeal*** 609.755, 632.83, 632.835 and 632.885; ***to renumber*** 625.02 (1); ***to renumber and amend*** 625.03 (1m) (e); ***to amend*** 40.51 (8), 40.51 (8), 40.51 (8m), 40.51 (8m), 49.67 (3) (am) 2. b., 66.0137 (4), 66.0137 (4), 111.91 (2) (n), 111.91 (2) (nm), 111.91 (2) (s), 111.998 (2) (n), 111.998 (2) (s), 120.13 (2) (g), 120.13 (2) (g), 185.983 (1) (intro.), 185.983 (1) (intro.), 600.01 (2) (b), 601.31 (1) (Lp), 601.31 (1) (Lr), 601.42 (4), 609.655 (4) (b), 625.13 (1), 625.14, 632.76 (2) (ac) 1., 632.76 (2) (ac) 2., 632.76 (2) (ac) 3. (intro.) and 632.895 (15) (c) (intro.); and ***to create*** 601.465 (1m) (d), 625.02 (1h), 625.02 (1p), 625.02 (2f), 625.02 (2s), 625.03 (1m) (e) 2., 625.03 (1m) (e) 3., 625.13 (3), 632.76 (2) (ac) 4. and chapter 636 of the statutes; **relating to:** implementing health insurance reform, extending the time limit for emergency rule procedures, specifying that any

health benefit exchange must be established by legislation, and granting rule−making authority.

Analysis by the Legislative Reference Bureau

This substitute amendment differs from 2011 Assembly Bill 210 (the bill) in the following respects:

1. In the bill, the Office of the Commissioner of Insurance (OCI) may promulgate any rule related to the provisions created in the bill as an emergency rule and is not required to provide evidence that promulgating the rule as an emergency rule is necessary for the preservation of public peace, health, safety, or welfare and is not required to provide a finding of emergency. The substitute amendment removes this exception so that OCI, in promulgating an emergency rule, would be required to provide evidence that the emergency rule is necessary for the preservation of public peace, health, safety, or welfare and required to provide a finding of emergency.

2. Under the bill, grandfathered plans are required to comply with the federal Patient Protection and Affordable Care Act (PPACA) relating to requirements for coverage of preventive health services. The substitute amendment removes this requirement for grandfathered plans.

3. PPACA defines a small employer as one that employs not more than 100 employees, but allows states to elect to define a small employer, for plan years beginning before January 1, 2016, as an employer with not more than 50 employees. The bill defines a small employer for purposes of the PPACA requirements as an employer with not more than 100 employees but specifically reserves the right to elect to substitute 50 for 100 for the definition of small employer. The substitute amendment provides that this election must be done through legislation.

4. The bill provides that if PPACA is found unconstitutional in its entirety and all appeals are exhausted or the time for appeal expires, insurers and self−insured governmental health plans are exempt from a number of provisions in the bill. The substitute amendment adds that, if PPACA is found unconstitutional in its entirety, the powers of OCI with respect to promulgating rules for, and enforcing, the PPACA requirements, as well as any rules or requirements already established related to those requirements, do not apply. The substitute amendment also provides that if any of PPACA's provisions are repealed, insurers and self−insured governmental health plans are exempt from those provisions, or if PPACA is found unconstitutional in part, insurers and self−insured governmental health plans are exempt from any rebate and report and coverage requirements that are found unconstitutional, and the powers of OCI with respect to promulgating rules for, and enforcing, provisions from which insurers and self−insured governmental health plans are exempt, as well as any rules or requirements already established related to those provisions, do not apply.

5. The substitute amendment specifies that any health benefit exchange established in this state under PPACA must be done so by legislation. The bill does not address the establishment of a health benefit exchange.

For further information, see the analysis for the bill.

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

SECTION 1. 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, ~~632.83, 632.835,~~ 632.85, 632.853, 632.855, 632.87 (3) to (6), 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896 and, so far as applicable, ch. 636.

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

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

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

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

SECTION 4. 40.51 (8m) of the statutes, as affected by 2011 Wisconsin Act .... (this act), is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 23. 609.755 of the statutes is repealed.

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

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

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

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

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

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

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

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

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

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

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

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

1. Credit accident and sickness insurance.

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

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

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

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

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

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

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

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

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

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

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

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

632.76 **(2)** (ac) 1. Notwithstanding par. (a) and except as provided in subd. 4., no claim or loss incurred or disability commencing 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.

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

632.76 **(2)** (ac) 2. Except as provided in ~~subd.~~ subds. 3. and 4., 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.

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

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

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

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

SECTION 39. 632.83 of the statutes is repealed.

SECTION 40. 632.835 of the statutes is repealed.

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

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

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

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

CHAPTER 636

HEALTH INSURANCE REFORM

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

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

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

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

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

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

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

(7) "Patient Protection and Affordable Care Act" means the federal Patient Protection and Affordable Care Act, P.L. 111−148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111−152.

(8) "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 exclusion, as defined in s. 632.745 (23).

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

(10) "Secretary" means the secretary of the federal department of health and human services.

(11) "Self−insured governmental health plan" means a self−insured health plan of the state or a county, city, village, town, or school district.

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

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

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

(2) EMERGENCY RULE−MAKING. Using the procedure under s. 227.24, the commissioner may promulgate any rule under this chapter or under s. 625.03 (1m) (e) 2. or 3. or 625.13 (3) as an emergency rule. Notwithstanding s. 227.24 (1) (c), any emergency rule promulgated under this subsection may remain in effect for up to one year and, in addition, may be extended under s. 227.24 (2).

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

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

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

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

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

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

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

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

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

2. Grandfathered health plans.

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

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

(c) Establish standards for independent review organizations.

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

636.15 Independent review organizations. (1) CERTIFICATION. (a) An independent review organization may not perform a review for purposes of the external appeals process established in accordance with standards promulgated

under s. 636.12 (1) (b) unless the organization is certified by the commissioner. Unless the commissioner provides otherwise by rule, only an independent review organization that is accredited by a nationally recognized private accreditation organization may be certified under this paragraph. An independent review organization must demonstrate to the satisfaction of the commissioner that it is unbiased and does not have a conflict of interest, as defined by the commissioner by rule. An organization certified under this paragraph must be recertified on a biennial basis.

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

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

(2) QUALITY ASSURANCE MECHANISM. An independent review organization shall have in operation a quality assurance mechanism to ensure the timeliness and quality of the independent reviews, the qualifications and independence of the clinical peer reviewers, and the confidentiality of the medical records and review materials.

(3) REASONABLE FEES. An independent review organization shall establish reasonable fees that it will charge for independent reviews and shall submit its fee

schedule to the commissioner for a determination of reasonableness and for prior approval. An independent review organization may not change any fees approved by the commissioner more than once per year and shall submit any proposed fee changes to the commissioner for prior approval.

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

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

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

(7) IMMUNITY FROM LIABILITY. (a) An independent review organization that is certified under this section is immune from any civil or criminal liability that may result because of an independent review determination made under the rules

promulgated under this chapter. An employee, agent, or contractor of a certified independent review organization is immune from any civil or criminal liability for any act or omission done in good faith within the scope of his or her powers and duties under the rules promulgated under this chapter.

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

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

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

636.25 Implementing health insurance coverage provisions. Subject to s. 636.35, notwithstanding any inconsistent provision in chs. 600 to 635 or chs. 644 to 646, and unless the commissioner provides otherwise by rule under s. 636.10, all of the following apply:

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) *Coverage of dependent students on medically necessary leave of absence.* Section 2728 (42 USC 300gg−28).

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

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

(a) *Coverage of dependent students on medically necessary leave of absence.* Section 2728 (42 USC 300gg−28).

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

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

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

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

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

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

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

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

636.35 Applicability if federal law found unconstitutional or repealed. **(1)** UNCONSTITUTIONAL. (a) If the Patient Protection and Affordable Care Act is found by a final decision of a federal court of competent jurisdiction to be unconstitutional in its entirety and unenforceable in this state, and if all appeals are exhausted or the time for appeal expires, on and after the first day of the 3rd month beginning after the date on which all appeals are exhausted or the time for appeal expires s. 636.10 does not apply, any rules promulgated or requirements established under s. 636.10 are void and may not be enforced, and insurers and self−insured governmental health plans are exempt from all of the following provisions:

1. Section 625.13 (3).

2. Section 636.18.

3. Section 636.25, except for the extension of dependent coverage requirements described in s. 636.25 (1) (h) and (3) (b).

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

(b) If the Patient Protection and Affordable Care Act is found by a final decision of a federal court of competent jurisdiction to be unconstitutional in part and unenforceable in part in this state, and if all appeals are exhausted or the time for appeal expires, on and after the first day of the 3rd month beginning after the date on which all appeals are exhausted or the time for appeal expires all of the following apply:

1. Insurers and self−insured governmental health plans are exempt from any provisions of the Public Health Service Act referred to in ss. 636.18 and 636.25 that correspond to the provisions of the Patient Protection and Affordable Care Act that

are found to be unconstitutional, except for the extension of dependent coverage requirements described in s. 636.25 (1) (h) and (3) (b).

2. Section 636.10 does not apply with respect to the provisions described in subd. 1. from which insurers and self−insured governmental health plans are exempt, and any rules promulgated or requirements established under s. 636.10 with respect to those provisions are void and unenforceable.

(2) REPEALED. If any provision of the Public Health Service Act referred to in this chapter is repealed, on and after the date on which the repeal is effective all of the following apply:

(a) Insurers and self−insured governmental health plans are exempt from the provision of the Public Health Service Act referred to in this chapter that is repealed, except for the extension of dependent coverage requirements described in s. 636.25 (1) (h) and (3) (b).

(b) Section 636.10 does not apply with respect to any provision described in par. (a) from which insurers and self−insured governmental health plans are exempt, and any rules promulgated or requirements established under s. 636.10 with respect to the provision are void and unenforceable.

(3) INAPPLICABILITY. This section does not apply after January 1, 2020.

SECTION 44. Nonstatutory provisions.

(1) ESTABLISHMENT OF HEALTH BENEFIT EXCHANGE. Any health benefit exchange established in this state under section 1311 (b) of the Patient Protection and Affordable Care Act, as defined in section 636.01 (7) of the statutes, as created by this act, must be established by legislation.

SECTION 45. Initial applicability.

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

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

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

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

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

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

(d) Disability insurance policies, and self−insured governmental or school district health plans, that are grandfathered health plans, as defined in section 636.01 (2) of the statutes, as created by this act, that cover employees who are affected by a collective bargaining agreement containing provisions inconsistent

with this act, and that are renewed, extended, or modified on the earlier of the following:

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

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

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

SECTION 46. Effective dates. This act takes effect on the day after publication, except as follows:

(1) HEALTH INSURANCE COVERAGE PROVISIONS. The treatment of sections 40.51 (8) (by SECTION 2) and (8m) (by SECTION 4), 49.67 (3) (am) 2. b., 66.0137 (4) (by SECTION 7), 111.91 (2) (n) and (nm), 111.998 (2) (n), 120.13 (2) (g) (by SECTION 14), 185.983 (1) (intro.) (by SECTION 16), 609.755, 632.76 (2) (ac) 1., 2., 3. (intro.), and 4., 632.885, 632.895 (15) (c) (intro.), 636.25, and 636.35 of the statutes and SECTION 45 (1) of this act take effect on the first day of the 6th month beginning after publication.

(2) INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE RATING. The treatment of sections 601.465 (1m) (d), 625.02 (1), (1h), (1p), (2f), and (2s), 625.13 (1) and (3), and 625.14 of the statutes, the renumbering and amendment of section 625.03 (1m) (e)

of the statutes, and the creation of section 625.03 (1m) (e) 2. and 3. of the statutes take effect on September 1, 2011, or on the day after publication, whichever is later.

(END)