



State of Wisconsin
1999 - 2000 LEGISLATURE

LRBs0148/1
PJK&RPN:wlj:km

**ASSEMBLY SUBSTITUTE AMENDMENT 2,
TO 1999 ASSEMBLY BILL 518**

October 26, 1999 - Offered by Representative WASSERMAN.

1 **AN ACT to repeal** 609.15 (title) and (1) (intro.) and 609.22 (4) (a) 2.; **to renumber**
2 609.15 (1) (c), 609.15 (2) (c), 609.15 (2) (d) and 609.15 (2) (e); **to renumber and**
3 **amend** 609.15 (1) (a), 609.15 (1) (b), 609.15 (2) (intro.), 609.15 (2) (a) and 609.15
4 (2) (b); **to amend** 40.51 (8), 40.51 (8m), 600.01 (2) (b), 601.42 (4), 609.05 (3),
5 609.22 (4) (a) 3., 609.39 and 609.655 (4) (b); **to repeal and recreate** 609.22 (4)
6 (a) 1.; and **to create** 111.91 (2) (r), 601.31 (1) (Lp), 601.31 (1) (Lr), 609.39, 632.83
7 and 632.835 of the statutes; **relating to:** requiring insurers to establish
8 internal grievance procedures, independent review of certain coverage
9 determinations made by health benefit plans, obtaining the services of
10 specialist providers, suing managed care plans and granting rule-making
11 authority.

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

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

2 40.51 **(8)** Every health care coverage plan offered by the state under sub. (6)
3 shall comply with ss. 631.89, 631.90, 631.93 (2), 632.72 (2), 632.746 (1) to (8) and (10),
4 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (5),
5 632.895 (5m) and (8) to (13) and 632.896.

6 **SECTION 2.** 40.51 (8m) of the statutes is amended to read:

7 40.51 **(8m)** Every health care coverage plan offered by the group insurance
8 board under sub. (7) shall comply with ss. 632.746 (1) to (8) and (10), 632.747,
9 632.748, 632.83, 632.835, 632.85, 632.853, 632.855 and 632.895 (11) to (13).

10 **SECTION 3.** 111.91 (2) (r) of the statutes is created to read:

11 111.91 **(2)** (r) The requirements related to internal grievance procedures under
12 s. 632.83 and independent review of certain health benefit plan determinations
13 under s. 632.835.

14 **SECTION 4.** 600.01 (2) (b) of the statutes is amended to read:

15 600.01 **(2)** (b) Group or blanket insurance described in sub. (1) (b) 3. and 4. is
16 not exempt from ss. 632.745 to 632.749, 632.83 or 632.835 or ch. 633 or 635.

17 **SECTION 5.** 601.31 (1) (Lp) of the statutes is created to read:

18 601.31 **(1)** (Lp) For certifying as an independent review organization under s.
19 632.835, \$400.

20 **SECTION 6.** 601.31 (1) (Lr) of the statutes is created to read:

21 601.31 **(1)** (Lr) For each biennial recertification as an independent review
22 organization under s. 632.835, \$100.

23 **SECTION 7.** 601.42 (4) of the statutes is amended to read:

24 601.42 **(4)** REPLIES. Any officer, manager or general agent of any insurer
25 authorized to do or doing an insurance business in this state, any person controlling

1 or having a contract under which the person has a right to control such an insurer,
2 whether exclusively or otherwise, any person with executive authority over or in
3 charge of any segment of such an insurer's affairs, any individual practice
4 association or officer, director or manager of an individual practice association, any
5 insurance agent or other person licensed under chs. 600 to 646, any provider of
6 services under a continuing care contract, as defined in s. 647.01 (2), any
7 independent review organization certified or recertified under s. 632.835 (4) or any
8 health care provider, as defined in s. 655.001 (8), shall reply promptly in writing or
9 in other designated form, to any written inquiry from the commissioner requesting
10 a reply.

11 **SECTION 8.** 609.05 (3) of the statutes is amended to read:

12 609.05 (3) Except as provided in ss. 609.22 (4), 609.65 and 609.655, a limited
13 service health organization, preferred provider plan or managed care plan may
14 require an enrollee to obtain a referral from the primary provider designated under
15 sub. (2) to another participating provider prior to obtaining health care services from
16 that participating provider.

17 **SECTION 9.** 609.15 (title) and (1) (intro.) of the statutes are repealed.

18 **SECTION 10.** 609.15 (1) (a) of the statutes is renumbered 632.83 (2) (a) and
19 amended to read:

20 632.83 (2) (a) Establish and use an internal grievance procedure that is
21 approved by the commissioner and that complies with sub. ~~(2)~~ (3) for the resolution
22 of enrollees' insureds' grievances with the ~~limited service health organization,~~
23 ~~preferred provider plan or managed care~~ health benefit plan.

24 **SECTION 11.** 609.15 (1) (b) of the statutes is renumbered 632.83 (2) (b) and
25 amended to read:

1 632.83 (2) (b) Provide enrollees insureds with complete and understandable
2 information describing the internal grievance procedure under par. (a).

3 **SECTION 12.** 609.15 (1) (c) of the statutes is renumbered 632.83 (2) (c).

4 **SECTION 13.** 609.15 (2) (intro.) of the statutes is renumbered 632.83 (3) (intro.)
5 and amended to read:

6 632.83 (3) (intro.) The internal grievance procedure established under sub. (1)
7 (2) (a) shall include all of the following elements:

8 **SECTION 14.** 609.15 (2) (a) of the statutes is renumbered 632.83 (3) (a) and
9 amended to read:

10 632.83 (3) (a) The opportunity for an enrollee insured to submit a written
11 grievance in any form.

12 **SECTION 15.** 609.15 (2) (b) of the statutes is renumbered 632.83 (3) (b) and
13 amended to read:

14 632.83 (3) (b) Establishment of a grievance panel for the investigation of each
15 grievance submitted under par. (a), consisting of at least one individual authorized
16 to take corrective action on the grievance and at least one ~~enrollee~~ insured other than
17 the grievant, if an enrollee insured is available to serve on the grievance panel.

18 **SECTION 16.** 609.15 (2) (c) of the statutes is renumbered 632.83 (3) (c).

19 **SECTION 17.** 609.15 (2) (d) of the statutes is renumbered 632.83 (3) (d).

20 **SECTION 18.** 609.15 (2) (e) of the statutes is renumbered 632.83 (3) (e).

21 **SECTION 19.** 609.22 (4) (a) 1. of the statutes is repealed and recreated to read:

22 609.22 (4) (a) 1. A managed care plan may not require an enrollee of the
23 managed care plan to obtain a referral for coverage of services provided by a
24 participating provider who is a physician licensed under ch. 448 and who specializes

1 in a particular type of medical practice, regardless of whether the participating
2 provider is the enrollee's primary provider.

3 **SECTION 20.** 609.22 (4) (a) 2. of the statutes is repealed.

4 **SECTION 21.** 609.22 (4) (a) 3. of the statutes is amended to read:

5 609.22 (4) (a) 3. A managed care plan must include information regarding
6 ~~referral procedures~~ the requirement under subd. 1. in policies or certificates
7 provided to enrollees and must provide such information to an enrollee or prospective
8 enrollee upon request.

9 **SECTION 22.** 609.39 of the statutes is created to read:

10 **609.39 Right to sue.** A person may bring an action in tort against a managed
11 care plan for a bad faith denial of coverage.

12 **SECTION 23.** 609.39 of the statutes, as created by 1999 Wisconsin Act ... (this
13 act), is amended to read:

14 **609.39 Right to sue.** A person may bring an action in tort against a managed
15 care plan for a bad faith denial of coverage, unless the person has requested and
16 obtained an independent review of the managed care plan's denial of coverage, as
17 provided under s. 632.835.

18 **SECTION 24.** 609.655 (4) (b) of the statutes is amended to read:

19 609.655 (4) (b) Upon completion of the review under par. (a), the medical
20 director of the managed care plan shall determine whether the policy or certificate
21 will provide coverage of any further treatment for the dependent student's nervous
22 or mental disorder or alcoholism or other drug abuse problems that is provided by
23 a provider located in reasonably close proximity to the school in which the student
24 is enrolled. If the dependent student disputes the medical director's determination,

1 the dependent student may submit a written grievance under the managed care
2 plan’s internal grievance procedure established under s. ~~609.15~~ 632.83.

3 **SECTION 25.** 632.83 of the statutes is created to read:

4 **632.83 Internal grievance procedure. (1)** In this section, “health benefit
5 plan” has the meaning given in s. 632.745 (11), except that “health benefit plan”
6 includes the coverage specified in s. 632.745 (11) (b) 2., 3., 5. and 10. and includes a
7 policy, certificate or contract under s. 632.745 (11) (b) 9. that provides only
8 limited–scope dental or vision benefits.

9 (2) Every insurer that issues a health benefit plan shall do all of the following:

10 **SECTION 26.** 632.835 of the statutes is created to read:

11 **632.835 Independent review of adverse and experimental treatment**
12 **determinations. (1) DEFINITIONS.** In this section:

13 (a) “Adverse determination” means a determination by or on behalf of an
14 insurer that issues a health benefit plan to which all of the following apply:

15 1. An admission to a health care facility, the availability of care, the continued
16 stay or other treatment that is a covered benefit has been reviewed.

17 2. Based on the information provided, the treatment under subd. 1. does not
18 meet the health benefit plan’s requirements for medical necessity, appropriateness,
19 health care setting, level of care or effectiveness.

20 3. Based on the information provided, the insurer that issued the health benefit
21 plan reduced, denied or terminated the treatment under subd. 1. or payment for the
22 treatment under subd. 1.

23 4. Subject to sub. (5) (c), the amount of the reduction or the value of the denied
24 or terminated treatment or payment exceeds \$200.

1 (b) “Experimental treatment determination” means a determination by or on
2 behalf of a health benefit plan to which all of the following apply:

3 1. A proposed treatment has been reviewed.

4 2. Based on the information provided, the treatment under subd. 1. is
5 determined to be experimental under the terms of the health benefit plan.

6 3. Based on the information provided, the insurer that issued the health benefit
7 plan denied the treatment under subd. 1. or payment for the treatment under subd.
8 1.

9 4. Subject to sub. (5) (c), the value of the denied treatment or payment exceeds
10 \$200.

11 (c) “Health benefit plan” has the meaning given in s. 632.745 (11), except that
12 “health benefit plan” includes the coverage specified in s. 632.745 (11) (b) 2., 3., 5. and
13 10.

14 (d) “Treatment” means a medical service, diagnosis, procedure, therapy, drug
15 or device.

16 **(2) REVIEW REQUIREMENTS; WHO MAY CONDUCT.** (a) Every insurer that issues a
17 health benefit plan shall establish an independent review procedure whereby an
18 insured under the health benefit plan, or his or her authorized representative, may
19 request and obtain an independent review of an adverse determination or an
20 experimental treatment determination made with respect to the insured.

21 (b) Whenever an adverse determination or an experimental treatment
22 determination is made, the insurer involved in the determination shall provide
23 notice to the insured of the insured’s right to obtain the independent review required
24 under this section, how to request the review and the time within which the review
25 must be requested. The notice shall include a current listing of independent review

1 organizations certified under sub. (4). An independent review under this section
2 may be conducted only by an independent review organization certified under sub.
3 (4) and selected by the insured.

4 (c) Except as provided in par. (d), an insured must exhaust the internal
5 grievance procedure under s. 632.83 before the insured may request an independent
6 review under this section. Except as provided in sub. (9), an insured who uses the
7 internal grievance procedure must request an independent review as provided in
8 sub. (3) (a) within 4 months after the insured receives notice of the disposition of his
9 or her grievance under s. 632.83 (3) (d).

10 (d) An insured is not required to exhaust the internal grievance procedure
11 under s. 632.83 before requesting an independent review if any of the following
12 apply:

13 1. The insured and the insurer agree that the matter may proceed directly to
14 independent review under sub. (3).

15 2. Along with the notice to the insurer of the request for independent review
16 under sub. (3) (a), the insured submits to the independent review organization
17 selected by the insured a request to bypass the internal grievance procedure under
18 s. 632.83 and the independent review organization determines that the health
19 condition of the insured is such that requiring the insured to use the internal
20 grievance procedure before proceeding to independent review would jeopardize the
21 life or health of the insured or the insured's ability to regain maximum function.

22 **(3) PROCEDURE.** (a) To request an independent review, an insured or his or her
23 authorized representative shall provide timely written notice of the request for
24 independent review, and of the independent review organization selected, to the
25 insurer that made or on whose behalf was made the adverse or experimental

1 treatment determination. The insurer shall immediately notify the commissioner
2 and the independent review organization selected by the insured of the request for
3 independent review. The insured or his or her authorized representative must pay
4 a \$20 fee to the independent review organization. If the insured prevails on the
5 review, in whole or in part, the entire amount paid by the insured or his or her
6 authorized representative shall be refunded by the insurer to the insured or his or
7 her authorized representative. For each independent review in which it is involved,
8 an insurer shall pay a fee to the independent review organization.

9 (b) Within 3 business days after receiving written notice of a request for
10 independent review under par. (a), the insurer shall submit to the independent
11 review organization copies of all of the following:

12 1. Any information submitted to the insurer by the insured in support of the
13 insured's position in the internal grievance under s. 632.83.

14 2. The contract provisions or evidence of coverage of the insured's health benefit
15 plan.

16 3. Any other relevant documents or information used by the insurer in the
17 internal grievance determination under s. 632.83.

18 (c) Within 5 business days after receiving the information under par. (b), the
19 independent review organization shall request any additional information that it
20 requires for the review from the insured or the insurer. Within 5 business days after
21 receiving a request for additional information, the insured or the insurer shall
22 submit the information or an explanation of why the information is not being
23 submitted.

1 (d) An independent review under this section may not include appearances by
2 the insured or his or her authorized representative, any person representing the
3 health benefit plan or any witness on behalf of either the insured or the insurer.

4 (e) In addition to the information under pars. (b) and (c), the independent
5 review organization may accept for consideration any typed or printed, verifiable
6 medical or scientific evidence that the independent review organization determines
7 is relevant, regardless of whether the evidence has been submitted for consideration
8 at any time previously. The insurer and the insured shall submit to the other party
9 to the independent review any information submitted to the independent review
10 organization under this paragraph and pars. (b) and (c). If, on the basis of any
11 additional information, the insurer reconsiders the insured's grievance and
12 determines that the treatment that was the subject of the grievance should be
13 covered, the independent review is terminated.

14 (f) If the independent review is not terminated under par. (e), the independent
15 review organization shall, within 30 business days after the expiration of all time
16 limits that apply in the matter, make a decision on the basis of the documents and
17 information submitted under this subsection. The decision shall be in writing,
18 signed on behalf of the independent review organization and served by personal
19 delivery or by mailing a copy to the insured or his or her authorized representative
20 and to the insurer. A decision of an independent review organization is binding on
21 the insured and the insurer.

22 (g) If the independent review organization determines that the health
23 condition of the insured is such that following the procedure outlined in pars. (b) to
24 (f) would jeopardize the life or health of the insured or the insured's ability to regain

1 maximum function, the procedure outlined in pars. (b) to (f) shall be followed with
2 the following differences:

3 1. The insurer shall submit the information under par. (b) within one day after
4 receiving the notice of the request for independent review under par. (a).

5 2. The independent review organization shall request any additional
6 information under par. (c) within 2 business days after receiving the information
7 under par. (b).

8 3. The insured or insurer shall, within 2 days after receiving a request under
9 par. (c), submit any information requested or an explanation of why the information
10 is not being submitted.

11 4. The independent review organization shall make its decision under par. (f)
12 within 72 hours after the expiration of the time limits under this paragraph that
13 apply in the matter.

14 **(3m)** STANDARDS FOR DECISIONS. (a) A decision of an independent review
15 organization regarding an adverse determination must be consistent with the terms
16 of the health benefit plan under which the adverse determination was made.

17 (b) A decision of an independent review organization regarding an
18 experimental treatment determination is limited to a determination of whether the
19 proposed treatment is experimental. The independent review organization shall
20 determine that the treatment is not experimental and find in favor of the insured
21 only if the independent review organization finds all of the following:

22 1. The treatment has been approved by the federal food and drug
23 administration.

24 2. Medically and scientifically accepted evidence clearly demonstrates that the
25 treatment meets all of the following criteria:

1 a. The treatment is proven safe.

2 b. The treatment can be expected to produce greater benefits than the standard
3 treatment without posing a greater adverse risk to the insured.

4 c. The treatment meets the coverage terms of the health benefit plan and is not
5 specifically excluded under the terms of the health benefit plan.

6 **(4) CERTIFICATION OF INDEPENDENT REVIEW ORGANIZATIONS.** (a) The commissioner
7 shall certify independent review organizations. An independent review
8 organization must demonstrate to the satisfaction of the commissioner that it is
9 unbiased, as defined by the commissioner by rule. An organization certified under
10 this paragraph must be recertified on a biennial basis to continue to provide
11 independent review services under this section.

12 (ag) An independent review organization shall have in operation a quality
13 assurance mechanism to ensure the timeliness and quality of the independent
14 reviews, the qualifications and independence of the clinical peer reviewers and the
15 confidentiality of the medical records and review materials.

16 (ap) An independent review organization shall determine the fees that it will
17 charge for independent reviews and submit its fee schedule to the commissioner for
18 approval. An independent review organization may not change any fees approved
19 by the commissioner more than once per year and shall submit any proposed fee
20 changes to the commissioner for approval.

21 (b) An organization applying for certification or recertification as an
22 independent review organization shall pay the applicable fee under s. 601.31 (1) (Lp)
23 or (Lr). Every organization certified or recertified as an independent review
24 organization shall file a report with the commissioner in accordance with rules
25 promulgated under sub. (5) (a) 4.

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

5 (d) The commissioner may revoke, suspend or limit in whole or in part the
6 certification of an independent review organization, or may refuse to recertify an
7 independent review organization, if the commissioner finds that the independent
8 review organization is unqualified or has violated an insurance statute or rule or a
9 valid order of the commissioner under s. 601.41 (4), or if the independent review
10 organization's methods or practices in the conduct of its business endanger, or its
11 financial resources are inadequate to safeguard, the legitimate interests of
12 consumers and the public. The commissioner may summarily suspend an
13 independent review organization's certification under s. 227.51 (3).

14 (e) The commissioner shall keep an up-to-date listing of certified independent
15 review organizations and shall provide a copy of the listing to all of the following:

- 16 1. Every insurer that is subject to this section, at least quarterly.
- 17 2. Any person who requests a copy of the listing.

18 **(5) RULES; REPORT; ADJUSTMENTS.** (a) The commissioner shall promulgate rules
19 for the independent review required under this section. The rules shall include at
20 least all of the following:

21 1. The application procedures for certification and recertification as an
22 independent review organization.

23 2. The standards that the commissioner will use for certifying and recertifying
24 organizations as independent review organizations, including standards for
25 determining whether an independent review organization is unbiased.

1 3. Procedures and processes, in addition to those in sub. (3), that independent
2 review organizations must follow.

3 4. What must be included in the report required under sub. (4) and the
4 frequency with which the report must be filed with the commissioner.

5 5. Standards for the practices and conduct of independent review
6 organizations.

7 6. Standards, in addition to those in sub. (6), addressing conflicts of interest by
8 independent review organizations.

9 (b) The commissioner shall annually submit a report to the legislature under
10 s. 13.172 (2) that specifies the number of independent reviews requested under this
11 section in the preceding year, the insurers and health benefit plans involved in the
12 independent reviews and the dispositions of the independent reviews.

13 (c) To reflect changes in the consumer price index for all urban consumers, U.S.
14 city average, as determined by the U.S. department of labor, the commissioner shall
15 at least annually adjust the amounts specified in sub. (1) (a) 4. and (b) 4.

16 **(6) CONFLICT OF INTEREST STANDARDS.** (a) An independent review organization
17 may not be affiliated with any of the following:

18 1. A health benefit plan.

19 2. A national, state or local trade association of health benefit plans, or an
20 affiliate of any such association.

21 3. A national, state or local trade association of health care providers, or an
22 affiliate of any such association.

23 (b) An independent review organization appointed to conduct an independent
24 review and a clinical peer reviewer assigned by an independent review organization

1 to conduct an independent review may not have a material professional, familial or
2 financial interest with any of the following:

3 1. The insurer that issued the health benefit plan that is the subject of the
4 independent review.

5 2. Any officer, director or management employe of the insurer that issued the
6 health benefit plan that is the subject of the independent review.

7 3. The health care provider that recommended or provided the health care
8 service or treatment that is the subject of the independent review, or the health care
9 provider's medical group or independent practice association.

10 4. The facility at which the health care service or treatment that is the subject
11 of the independent review was or would be provided.

12 5. The developer or manufacturer of the principal procedure, equipment, drug
13 or device that is the subject of the independent review.

14 6. The insured or his or her authorized representative.

15 **(6m) QUALIFICATIONS OF CLINICAL PEER REVIEWERS.** A clinical peer reviewer who
16 conducts a review on behalf of a certified independent review organization must
17 satisfy all of the following requirements:

18 (a) Be a health care provider who is expert in treating the medical condition
19 that is the subject of the review and who is knowledgeable about the treatment that
20 is the subject of the review through current, actual clinical experience.

21 (b) Hold a credential, as defined in s. 440.01 (2) (a), that is not limited or
22 restricted; or hold a license, certificate, registration or permit that authorizes or
23 qualifies the health care provider to perform acts substantially the same as those
24 acts authorized by a credential, as defined in s. 440.01 (2) (a), that was issued by a

1 governmental authority in a jurisdiction outside this state and that is not limited or
2 restricted.

3 (c) If a physician, hold a current certification by a recognized American medical
4 specialty board in the area or areas appropriate to the subject of the review.

5 (d) Have no history of disciplinary sanctions, including loss of staff privileges,
6 taken or pending by the medical examining board or another regulatory body or by
7 any hospital or government.

8 **(7) IMMUNITY.** (a) A certified independent review organization is immune from
9 any civil or criminal liability that may result because of an independent review
10 determination made under this section. An employe, agent or contractor of a
11 certified independent review organization is immune from civil liability and criminal
12 prosecution for any act or omission done in good faith within the scope of his or her
13 powers and duties under this section.

14 (b) A health benefit plan that is the subject of an independent review and the
15 insurer that issued the health benefit plan shall not be liable in damages to any
16 person for complying with any decision rendered by a certified independent review
17 organization during or at the completion of an independent review.

18 **(8) NOTICE OF SUFFICIENT INDEPENDENT REVIEW ORGANIZATIONS.** The
19 commissioner shall make a determination that at least one independent review
20 organization has been certified under sub. (4) that is able to effectively provide the
21 independent reviews required under this section and shall publish a notice in the
22 Wisconsin Administrative Register that states a date that is 2 months after the
23 commissioner makes that determination. The date stated in the notice shall be the
24 date on which the independent review procedure under this section begins operating.

1 **(9) APPLICABILITY.** The independent review required under this section shall be
2 available to an insured who receives notice of the disposition of his or her grievance
3 under s. 632.83 (3) (d) on or after the first day of the 7th month beginning after the
4 effective date of this subsection [revisor inserts date]. Notwithstanding sub. (2)
5 (c), an insured who receives notice of the disposition of his or her grievance under s.
6 632.83 (3) (d) on or after the first day of the 7th month beginning after the effective
7 date of this subsection [revisor inserts date], but before the date stated in the
8 notice published by the commissioner in the Wisconsin Administrative Register
9 under sub. (8) [revisor inserts date], must request an independent review no later
10 than 4 months after the date stated in the notice published by the commissioner in
11 the Wisconsin Administrative Register under sub. (8) [revisor inserts date].

12 **SECTION 27. Nonstatutory provisions.**

13 **(1) RULES REGARDING INDEPENDENT REVIEW.** The commissioner of insurance shall
14 submit in proposed form the rules required under section 632.835 (5) (a) of the
15 statutes, as created by this act, to the legislative council staff under section 227.15
16 (1) of the statutes no later than the first day of the 7th month beginning after the
17 effective date of this paragraph.

18 **SECTION 28. Initial applicability.**

19 **(1) SPECIALIST PROVIDERS UNDER MANAGED CARE PLANS.**

20 **(a)** Except as provided in paragraph (b), if a policy or certificate that is affected
21 by the treatment of sections 609.05 (3) and 609.22 (4) (a) 1., 2. and 3. of the statutes
22 contains terms or provisions that are inconsistent with the treatment of sections
23 609.05 (3) and 609.22 (4) (a) 1., 2. and 3. of the statutes, the treatment of sections
24 609.05 (3) and 609.22 (4) (a) 1., 2. and 3. of the statutes first applies to that policy or
25 certificate upon renewal.

1 (b) The treatment of sections 609.05 (3) and 609.22 (4) (a) 1., 2. and 3. of the
2 statutes first applies to policies or group certificates covering employes who are
3 affected by a collective bargaining agreement containing provisions that are
4 inconsistent with the treatment of sections 609.05 (3) and 609.22 (4) (a) 1., 2. and 3.
5 of the statutes that are issued or renewed on the earlier of the following:

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

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

9 (2) LAWSUITS AGAINST MANAGED CARE PLANS. The creation of section 609.39 of the
10 statutes first applies to claims arising on the effective date of this subsection.

11 **SECTION 29. Effective dates.** This act takes effect on the day after publication,
12 except as follows:

13 (1) The treatment of sections 609.15 (title), (1) (intro.), (a), (b) and (c) and (2)
14 (intro.), (a), (b), (c), (d) and (e), 609.655 (4) (b) and 632.83 of the statutes takes effect
15 on the first day of the 7th month beginning after publication.

16 (2) The treatment of section 632.835 (2), (3), (3m) and (5) (b) and (c) of the
17 statutes and the amendment of section 609.39 of the statutes take effect on the date
18 stated in the notice published by the commissioner of insurance in the Wisconsin
19 Administrative Register under section 632.835 (8) of the statutes, as created by this
20 act.

21 (END)