KATHLEEN VINEHOUT
STATE SENATOR

Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief and Revenue

April 22, 2009

Good Afternoon Chairman Erpenbach and Committee members.

Thank you for the opportunity to testify on my Five Point Health Insurance Reform Plan. Over the past several months, Commissioner Dilweg and I collaborated on reforms to our health insurance regulations to bring certainty and consumer protection to those who purchase health insurance, especially in the individual market.

Our work is before you in Senate Bills 70, 71, 72. In addition, Senate Bills 73 and 74 are simple modifications to the state's Health Insurance Risk Sharing Pool (HIRSP).

In the current economy people are losing their jobs, which means they are also losing their health coverage. More people are increasingly relying on the individual insurance market for coverage. People want to know when they buy insurance they are really getting the coverage they expected.

Yet Wisconsin falls behind many other states in setting rules to protect consumers.

A recent report released by Families USA gave Wisconsin a failing grade on state consumer protections in the individual health insurance market. The findings of the report cited Wisconsin's current 2-year time limit on pre-existing condition exclusions as too long. A majority of states limit pre-existing conditions to twelve months or less. Wisconsin can too.

Additionally, Wisconsin doesn't protect consumers from having claims denied because the insurance companies are digging back years into the policyholder's medical history and alleging the individual should have known about a pre-existing condition. Twenty five other states limit this practice.

The proposals before you today would improve protections for consumers in several important ways:

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Expanding Coverage

Health Insurance Coverage for Adult Children

- Require group and individual health insurance policies to cover unmarried adult children through 26 years of age under their parents' policies. The cost of coverage for adult children 19 through 26 years of age shall be included in the premium on the same basis as other dependent coverage. We know young adults are the least likely people to have coverage; approximately thirty percent of those age 19 to 29 are uninsured; thirty states require some coverage of adult children; ten states do not define dependents or allow this coverage even if they are not in school or financially dependent.

- In addition to adult child coverage through the age of 26, also require group and individual health insurance policies to cover any child, regardless of age, under their parent's policy whose education is interrupted by services in the National Guard or Reserves.

Modifications to HIRSP Eligibility and Flexibility in Maximum Lifetime Limits

- Currently people seeking coverage under the state's Health Insurance Risk Sharing Pool (HIRSP) must demonstrate that they have, in the past 9 months prior to application, received a notice of rejection from 2 or more insurers.

- This bill revises current law to require only one rejection notice for eligibility into HIRSP.

- Major medical expense coverage offered under HIRSP is currently subject to a lifetime limit of $1,000,000. This bill allows the HIRSP Authority to increase the lifetime limit.

- Both of these modifications have the approval of the HIRSP Board.

Increasing Portability and Making It Easier For People To Change Insurance

Choices in Coverage

- The proposal allows consumers, at the time of their policy renewal to change coverage to a comparable product currently offered by their insurer or modify their existing coverage. These choices may include additional coverage, more limited benefits or higher deductibles. The consumer shall not be subject to any additional underwriting or any new preexisting conditions exclusion that did not apply to his or her original coverage.

Creditable Coverage

- The maximum pre-existing condition exclusion period for **group health insurance policies** is 12 months. Currently, if a person loses health insurance coverage but picks up coverage within **63** days, they can apply creditable coverage to the 12 month exclusion period.

- This bill allows individuals who lose health insurance coverage and pick up new group coverage within **90** days, to apply creditable coverage to the maximum pre-existing condition exclusion period on the new group policy.

Setting Limits on How "Pre-Existing Conditions" Can Be Used to Limit Coverage and Deny Claims

Limit Pre-existing Condition Exclusion to One Year

- The Kaiser Family Foundation explains the "maximum pre-existing condition exclusion period" as a limit on post-claims underwriting. Any claim filed during the exclusion period can be investigated as possibly pre-existing and, if found to be so, can be denied and coverage for all further care for that condition can be excluded during the exclusion period.

- The current pre-existing condition exclusion period for individual health insurance coverage in Wisconsin is 2 years. This bill limits the pre-existing condition exclusion period for individual health insurance coverage to 1 year. (at least 25 states are at one year or less).

Limit Pre-existing Condition Look Back Period

- The Kaiser Family Foundation explains the, "maximum look back period" as limiting the period of history preceding purchase of a policy that can be investigated for evidence of a preexisting condition.

- Current Wisconsin law does not place a limit on the maximum look back period. This bill would limit the "maximum look back period" for pre-existing conditions to 1 year. (26 states do this).

Require "Objective Standard" in Determining Whether a Pre-Existing Condition was Present Prior to Application for Coverage

- This proposal would apply the "objective standard" rather than the "prudent person standard" in determining pre-existing conditions under individual health insurance policies.

- The 'objective standard' allows only those conditions for which someone actually received medical advice, diagnosis, care or treatment prior to enrollment to be counted as pre-existing.

- Current law references the "prudent person standard" in determining whether a pre-existing condition was present prior to the individual's date of enrollment for coverage by an individual health plan.

- The 'prudent person" standard includes conditions that were never diagnosed, but which exhibited symptoms for which an ordinary prudent person would have sought medical advice, care or treatment. 18 states follow the objective standard for defining pre-existing conditions.

Bringing Fairness to Appeals

Consumers Can Choose an External Review for Rescission or Exclusion

- Current law allows for independent review of adverse and experimental treatment determinations. There is no provision for review for dropped coverage or exclusion of pre-existing conditions.

- This proposal allows for an independent review of rescissions and pre-existing exclusion denial determinations at no cost to the consumer.

Evaluating Results

Standard Application Form

- This proposal gives the Commissioner of Insurance the authority to establish uniform insurance application with standard underwriting questions.

Evaluation and Annual Reporting

- This proposal also requires every insurer to annually report the total number of individual health insurance policies issued and the total number of policy cancellations or rescissions that were initiated or completed.

I urge the committee to support these health insurance proposals. While we continue to concentrate on reaching agreement on big picture health reform, we can take the small and immediately achievable steps to bring increased coverage, certainty and fairness to health insurance.

Thank you for your consideration.

FIVE POINT PLAN TO REFORM HEALTH INSURANCE: FACT SHEET
Introduced by Sen. Kathleen Vinehout (D-Alma)

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- The current pre-existing condition exclusion period for individual health insurance coverage in Wisconsin is 2 years. This bill limits the pre-existing condition exclusion period for individual health insurance coverage to 1 year.

- According to a Kaiser Family Foundation Fact Sheet, 23 other states use a 1 year pre-existing condition exclusion period.

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Five Point Plan to Reform Health Insurance Bill Numbers

SB 70/AB 118 – Relating to: coverage of dependents under health care plans.

SB 71/AB 100 - Relating to: preexisting condition exclusions, modifications at renewal, and establishing a standard application for individual health benefit plans and granting rule-making authority.

SB 72/AB 108 - Relating to: portability under group health benefit plans and independent review of insurance policy rescissions and preexisting condition exclusion denials under group and individual health benefit plans.

SB 73/AB 111 - Relating to: the lifetime limit under the Health Insurance Risk-Sharing Plan.

SB 74/AB 112- Relating to: health insurance coverage denials for eligibility under the Health Insurance Risk-Sharing Plan.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

Wisconsin.gov

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Testimony of Eileen Mallow, Assistant Deputy Commissioner
To the Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief and Revenue
Senate Bill 70
April 22, 2009

Chairman Erpenbach and Members of the Committee:

Thank you for the opportunity to testify in support of Senate Bill 70, relating to coverage of dependents under health care plans.

In an attempt to directly address the young adult, uninsured population, states are enacting legislation to extend dependent benefits to older children.[1] For instance, those who enroll in college full time are the most likely in their age group to have insurance coverage, primarily because they are able to maintain eligibility under their parents' employer's policies.[2]

According to the National Conference of State Legislatures, there are twenty states requiring health insurance coverage for young adult dependents, without the caveat they be enrolled as full or part-time students or be a member of the armed services.

In Wisconsin, health insurers are not required to provide health insurance coverage to adult children. However, many insurers covering most of the commercial market do extend coverage to adult children if they are full time students, under the age of 25 and financially dependent on the subscriber (their parents).

In an economy where new graduates are not guaranteed employment upon graduation and employers are imposing probationary periods before health insurance coverage is available, SB 70 provides a common sense approach to ensuring generally low-risk young adults are insured until they are able to access coverage through their own employer.

Specifically, Senate Bill 70 requires health insurers to extend coverage to adult children, upon request of the insured, if they are under the age of 27, unmarried and do not have access to less expensive coverage through their employer. The bill also requires coverage for students whose education is interrupted by the U.S. armed forces, as long as the child is under the age of 27 when called to federal active duty.

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[1] National Conference of State Legislatures. *The Changing Definition of "Dependent." Who is Insured and for How Long?*
[2] R.Colins, C. Schoen, J. L. Kriss, M. M. Doty, and B. Mahoto, "*Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help,*" The Commonwealth Fund, May 2006 p. 2

SB 70 is a positive step forward in ensuring young adults have access to health insurance coverage.

Thank you for the opportunity to testify in favor of SB 70 today. I welcome any questions.

WNA
WISCONSIN NURSES ASSOCIATION

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info@wisconsinnurses.org • www.wisconsinnurses.org

TO: Chairperson Jon Erpenbach and Members of the Senate Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

FROM: Gina Dennik-Champion, MSN, RN, MSHA
Executive Director, Wisconsin Nurses Association

DATE: April 22, 2009

RE: Support of SB 70 – Relating to coverage of dependents under health care plans.

Good morning Chairperson Erpenbach and members of the Senate Health, Health Insurance, Privacy, Property Tax Relief, and Revenue Committee. My name is Gina Dennik-Champion, I am a registered nurse and I am here today representing the Wisconsin Nurses Association (WNA). WNA is the professional association for all RNs in Wisconsin. As a professional nursing association, we collectively and collaboratively advocate for access to comprehensive quality health care services for all people. This in turn provides the person an increased opportunity for maintaining health and sustaining a life of quality.

Thank you for allowing me the opportunity to share WNA's support of SB 70, Relating to coverage of dependents under health care plans. WNA extends appreciation to Senator Vinehout, for sponsoring this legislation and the members of this committee who are supporting this legislation.

For background purposes, WNA would like to share that we are members of a health care reform discussion group that was facilitated by Senator Kathleen Vinehout and Representative Donna Seidel. This group consists of professional health care practitioners, health care providers, insurance companies, and other advocacy groups. The group discussed the barriers that exist for consumers in obtaining health insurance and the changes needed so that access to health care could be achieved. WNA is very appreciative of Senator Vinehout and Representative Seidel in bringing this group together, as we now have an opportunity for removing some of these barriers.

WNA has held a long-standing interest in health care reform. WNA, along with other members of the Wisconsin Nursing Coalition, developed a document in 1999 which has recently been revised that describes professional nursing's opinions and recommendations for health care reform. This document, *The Wisconsin Community of Nursing Agenda for Healthcare Reform* (January 2009), describes the need for a reformed health care system. WNA, as part of the nursing community, remains optimistic that true health care reform will occur, as we cannot as a society continue to have:

- 350,000 persons go without care or enter the system sicker, at higher cost entry points;
- Limited access to health care in rural communities and dense urban areas;
- Decreased personal incomes as more out-of-pocket health care costs rise;
- A rapidly growing aging and culturally diverse population;
- Health disparities among underserved populations;
- Health care workforce shortages;
- Annual double digit increases in health costs;
- Decreased profits for business as health insurance costs rise;
- Gaps, fragmentation and duplication in delivery of services;
- A "system" that is complex, confusing and wasteful; and
- Environmental practices that negatively impact healthy living.

As we wait for health care reform to occur nationally and in Wisconsin, we cannot ignore the real issues that are impacting real people in the pursuit of health care coverage for all. SB 70 addresses the issue of our young adults lacking access to health insurance. SB 70 will promote lower health care costs as the young adult can access affordable primary care services which in turn will promote prevention and health promotion.

Having access to these services can reduce the costs associated with accessing the more expensive services such as the emergency room. WNA encourages the passing of SB 70 as it addresses the type of health care services young adults require the most which is primary care. There are however, those instances when emergency care or hospitalization may be required. Having health insurance will avoid a young adult having to take out a loan or use a credit card to pay for their needed care. Given the current economic crisis, situations like this have a high probability of increasing. Our young adults should not have to become destitute to have access to health care, when they could be covered under their parents' current plan.

Thank you for providing WNA the opportunity to present our support of SB 70.

The Wisconsin Nursing Community Agenda for Health Care Reform

This is the response of Wisconsin's registered nurses to the growing concerns about our failing health care delivery system. Nurses believe a reformed health care delivery system is cost-effective and has objectives that focus upon *promoting, ensuring and sustaining health.*

Challenges:

- 350,000 persons go without care or enter the system sicker, at higher cost entry points
- Limited access to health care in rural communities and dense urban areas
- Decreased personal incomes as more out-of-pocket health care costs rise
- A rapidly growing aging and culturally diverse population
- Health disparities among underserved populations
- Health care workforce shortages
- Annual double digit increases in health costs
- Decreased profits for business as health insurance costs rise
- Gaps, fragmentation and duplication in delivery of services
- A "system" that is complex, confusing and wasteful
- Environmental practices that negatively impact healthy living

Four Tenets of Care:

Nurses are a critical part of the health care delivery system by promoting health and providing care during illness and disease throughout the lifespan of the individual.

Nurses advocate for the *coordination* of health services and health care access for all. The *Wisconsin Nursing Community's Agenda for Health Care Reform* identifies four tenets of care to increase the opportunities for maintaining health and sustaining a life of quality:

Health Promotion and Illness and Disease Prevention

- Prioritize prevention of illness/disease through screening, vaccinations, prompt treatment and interventions that limit the progression of disease
- Focus on healthy lifestyles and health promotion across the lifespan
- Support the health priorities in *"Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public"*
- Support public policies that encourage healthy choices/decisions

Coverage that does not provide access to preventive care will continue to increase costs as consumers invariably become subject to disease and require more treatment and services.

Health Literacy

- Provide individuals with information and support to better negotiate complex health care systems and use knowledge to effectively enhance their health
- Deliver services that are culturally sensitive and appropriate
- Disseminate reliable and user-friendly information that is transparent about quality and cost
- Assure health care providers have the tools, skills and systems that support consumer health literacy
- Empower individuals to make health choices

Increased health literacy improves health outcomes.

Patient Safety

- Promote patient safety by protecting the rights and responsibilities of all health care providers to report unsafe activities or practices
- Design work environments and equipment that reduce patient and staff injuries

National estimates indicate 45,000 to 98,000 patients dies each year as a result of health care errors. Health care errors are a wasteful and unnecessary drain on limited health care resources and cause patients and families great suffering.

Coordinated Chronic Disease Management

- Increase use of technologies that support communication among consumers and health care providers
- Coordinate care services that provide ongoing support to individuals and their families

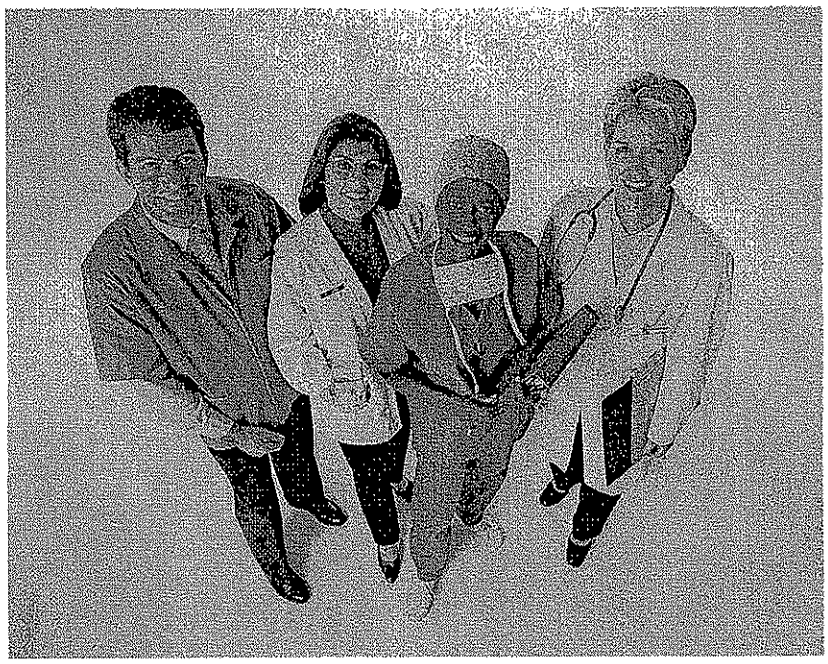
Seventy-eight percent of all medical dollars are spent treating chronic disease, making people with chronic conditions the largest, most costly and fastest growing services group. The current health care infrastructure does not yet effectively nor effeciently address the needs of persons with chronic conditions.

Wisconsin Nurses – *76,000 strong provide services in all care and community settings throughout Wisconsin. Protecting the health of the public, optimizing health outcomes and meeting the expected increase in demand for health services is critical to the safety and welfare of our society. Knowledge about effective and efficient care practices among providers and consumers alike will require increased dialogue and further partnering with policy makers, businesses, social service systems and consumers. We are committed to engage fully in the work ahead.*

Contact

For more information contact the Wisconsin Nurses Association at (608) 221-0383 or www.wisconsinnurses.org

The Wisconsin Nursing Community Agenda for Health Care Reform



Date: January 23, 2009

This statement is supported by the following Wisconsin Nursing Coalition Members

Wisconsin Nurses Association
Wisconsin Emergency Nurses Association
Wisconsin DDNA (WiDDNA)
American Association of Critical Care Nurses, Greater Milwaukee Area Chapter
Wisconsin Association of Pediatric Nurse Associates & Practitioners
Wisconsin League of Nursing

NURSING'S AGENDA FOR HEALTH CARE REFORM

Introduction

Wisconsin's seventy-six thousand registered nurses are acknowledged leaders in our health care system, providing care in various settings throughout Wisconsin. Nurses are a critical part of the health care delivery system by promoting health and providing care during illness and disease throughout the lifespan of the individual. Among all providers, they are advocates in seeking, pursuing and ensuring coordination of health services. Wisconsin nurses understand the importance of an effective healthcare system that responds to the current and emerging health needs of individuals, families and communities. This document sets forth policy recommendations for healthcare system reforms that increase access, extend care to all persons and improve the health of the public. Wisconsin nurses call for reform that provides access to health care services for all and access to a full range of services for all individuals with an emphasis on four basis tenets of care. They are:

- **Prevention and health promotion**
- **Health literacy**
- **Patient safety**
- **Coordinated chronic disease management**

Underlying Principle: Access to Health Services For All

Wisconsin nurses believe it is essential that reform afford all persons in Wisconsin access to a standard package of evidence-based, quality healthcare services that provide a coordinated continuum of care across the lifespan. Access to services would include the following:

- *Health Promotion*
- *Illness and Disease Prevention*
- *Primary healthcare*
- *Outpatient professional services and therapies*
- *Coordinated disease management*
- *Emergency and acute care*
- *Mental health and substance abuse care*
- *Prescription drugs, medical supplies and equipment*
- *Hearing, oral health and vision care*
- *Rehabilitative and restorative care*
- *Long term care*
- *Palliative and end of life care*
- *School based services*

To provide access for all, we endorse the following strategies:

- Spread financial risk through increased access to existing and larger purchasing pools

- Achieve competence in healthcare organizations and individual healthcare providers
- Adequate funding and reimbursement levels are expected to support programs
- Promote billing and reimbursement systems that increase cost awareness, sensitivity and transparency among consumers, providers, employers and purchasers
- Stress health promotion and illness and disease prevention to reduce the need for the intensive resource investments in disease intervention
- Develop a sustainable healthcare workforce

Significant annual rises in healthcare costs and policy recommendations that curtail access to services cannot be allowed to go unchecked. The four tenets outlined in this position paper are derived from the belief that overall reform needs to begin by encouraging all healthcare providers, purchasers, consumers and policymakers to think in terms of a health agenda rather than a healthcare financing agenda.

Health Promotion and Illness and Disease Prevention

Goal: To build a delivery system that reinforces and reimburses preventive services across the life span and supports health consumers in being knowledgeable and engaged partners in preventive care strategies

Health is defined as "a state of well-being and capability to function in the face of changing circumstances" (Durch, Bailey, & Soto, 1997). Prevention is the cornerstone to optimal health. Preventive services help individuals become and stay healthy. These services range from *primary prevention* with focuses on health education, disease and injury prevention and those legislative and regulatory supported preventive strategies; to *secondary prevention* which focuses on screening, early detection and prompt treatment; to *tertiary prevention* which focuses on limiting the progression of disease. The goal to promote health across the life span by creating and assuring conditions in which all people of Wisconsin can achieve and maintain health throughout their lives.

Health includes both personal and societal dimensions. The personal dimension of health includes acquiring knowledge, acting upon that knowledge and creating healthful opportunities for individuals and families to make decisions. The societal dimension of health includes coordinated efforts within the community in partnership with the public health system to assure conditions that foster good health.

Illness and Disease Prevention is a major vehicle by which health status is attained and maintained. Coverage that does not provide access to preventive care will continue to increase costs as consumers invariably become subject to disease and require more treatment and services.

Wisconsin nurses support:

- Wisconsin's *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*, which cites key priorities that influence both health and illness. Listed alphabetically below, they are:
    - Access to Primary and Preventive Health Services
    - Adequate and Appropriate Nutrition
    - Alcohol and Other Substance Use and Addiction Services

- Environmental and Occupational Health Hazards
- Existing, Emerging, and Re-emerging Communicable Diseases
- High Risk Sexual Behavior
- Intentional and Unintentional Injuries and Violence
- Mental Health and Mental Disorders
- Overweight, Obesity, and Lack of Physical Activity
- Social and Economic Factors that Influence Health
- Tobacco Use and Exposure

Health Literacy

Goal: To support consumers as they negotiate complex healthcare systems and use information to effectively enhance their health.

The Institute of Medicine (IOM) defines health literacy as "the degree to which individuals have the capacity to obtain, process and understand health information and services needed to make appropriate health decisions." Health communication contributes to all aspects of health promotion and disease prevention. Communication is critical for people's exposure to, search for and use of health information. This includes the ability to reduce or eliminate unhealthy behaviors and adopt healthy ones. Health illiteracy is associated with severe disease outcomes and more costly care. Higher costs result from medication and treatment errors, more hospitalizations, longer hospital stays, more provider visits and increased use of inappropriate emergency room services. Death rates from chronic disease, communicable disease and injuries are inversely related to the level of understanding health consumers have about their lifestyle choices, conditions, and treatment options. Consumers are faced with a number of challenges as they seek health information and search for strategies to navigate an increasingly complex health system.

Wisconsin nurses support:

- Consumer empowerment to make healthy and responsible choices and decisions
- Advocacy for and participation in educational activities that result in increased consumer and healthcare provider competencies
- Healthcare practitioners being provided the tools, skills and systems that support assessment of consumer health literacy
- Active participation by all practitioners to communicate good health practices beginning at infancy and continuing into adulthood
- Delivery of services that are culturally competent and reflective of individual health beliefs
- Consumer involvement in continuous learning and ongoing communication of information between caregivers, organizations and the general public
- Dissemination of information about population health risks through the construction and increased use of public health messages and campaigns
- Further development of online personal health records, health web sites, interactive personal health tools and telemedicine

Patient Safety

Goal: To effect fundamental and sustainable improvements in patient safety.

Patient safety is the prevention of healthcare errors and the elimination of patient injury caused by healthcare errors. (NPSF® Board July 2003). A healthcare error is defined as an unintended healthcare outcome caused by a defect in the delivery of care to a patient. Healthcare errors may be errors of commission (doing the wrong thing), omission (not doing the right thing), or execution (doing the right thing incorrectly). Errors may be made by any member of the healthcare team as well as a consumer in any care setting. They can happen at any point in the care process or result from a systems failure. It is estimated that nationally, between 44,000 and 98,000 (2000) patients die each year as a result of healthcare errors. This number exceeds deaths resulting from motor vehicle accidents, breast cancer and AIDS. The total costs associated with healthcare errors are estimated to be between $17 billion and $29 billion (IOM, 2004). Patients, their families and society suffer as a result of healthcare errors producing a wasteful drain on our limited health care resources. Errors are grossly underreported in most healthcare settings because of cultures that shame those involved or demand "silence" for fear of employer, civil and/or criminal actions (ISMP, 2004). It is impossible to correct errors if they are not reported. Errors that plague our healthcare system erode public trust.

Adequate registered nurse staffing and supportive practice environments are proving to be a strong influence in achieving good patient outcomes. Nurses are the surveillance system for early detection and intervention for adverse health occurrence. Studies reveal that for prevention of medication errors registered nurses intercepted 87% of all potential errors. (IOM, 2004). Research by Linda Aiken of the University of Pennsylvania cites that patient mortality rose seven percent for every additional patient added to the average nurse's workload. This study, as reported in the Journal of the American Medical Association on October 2002, affirms the critical role registered nurses play in patient safety when able to make direct assessment and life saving interventions. Further support for designing effective nurse work environments to promote patient safety comes from the Institute of Medicine Quality Chasm Series; *"Keeping Patients Safe: Transforming the Work Environment of Nurses,"* (National Academies of Science, 2004).

Wisconsin nurses support:

- Developing systems that protect the rights and responsibilities of all health care providers with respect to reporting activities or practices that jeopardize patient safety
- Legislation that protect individual healthcare providers from criminalization for unintentional medical errors
- Designing work environments and equipment that prevent and mitigate patient and staff injuries
- Optimizing a registered nurse workforce to maximize patient safety
- Using best practices to encourage health care organizations to become "magnet recognition" facilities which have higher retention rates and improved patient outcomes
- Promoting professional development and competencies of nurses with respect to creating and supporting patient safety systems
- Promoting patient safety by supporting professional organizations, agencies and associations that improve patient safety
- Implementing coordination strategies to reduce error in managing chronic disease

Coordinated Chronic Disease Management

Goal: To help people with chronic conditions prevent, delay, or minimize disease and disability progession, and maximize health and well being.

"Disease management is a system of coordinated healthcare interventions and communications for populations in which patient self-care efforts are significant. Disease management supports the practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications by utilizing evidence-based practice guidelines and patient empowerment strategies; and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health" (Disease Management Association of America, 2004). Disease management covers the continuum of chronic disease care. It extends from early detection (the identification of non-symptomatic, undiagnosed, or high-risk populations) and early interventions to prevention or reduction of the chronic disease risk complications through supportive end-of-life care. Disease management is a strategy concerned with an individual's health over extended periods. It differs significantly from the current healthcare system that has been designed to deliver acute and episodic, but not chronic care.

Seventy-eight (JAMA, 1996) percent of all medical dollars are spent treating chronic disease, making people with chronic conditions our largest, highest-cost, and fastest-growing services group. The incidence of chronic disease increases with age, suggesting that the number of adults living with chronic disease will continue to increase as the number of older adults (aged 65 years and older) increases. By 2030 over 20% (JAMA, 2996) of the U.S. population will be 65 years and older. Just as noteworthy is the fact that although many of the individual affected be older adults, chronic disease affects children and adults of all ages.

The current health care infrastructure is not efficient in addressing the needs of persons with chronic conditions. Individuals with multiple chronic disease conditions require multiple health care practitioners that are specialists in treating and managing the specific disease. Individuals that have these multiple chronic disease states require coordination of all the care and services provided so that fragmented, duplicated, redundant and contraindicated care can be avoided. In addition, coordination of the complementary care and services that provide ongoing support to those with chronic conditions as well as their families is critical for effective disease management.

Wisconsin nurses support:

- Services that integrate and coordinate care across care delivery systems
- Programs that support advocacy for individuals with chronic disease and their families
- Activities that guide and support individuals in developing self-care management skills
- Technologies (e.g., telemedicine and shared electronic medical record and data collection systems) that support communication among individuals, healthcare providers and care delivery systems
- Elimination of regulatory and institutional barriers to services provided by qualified providers (e.g., advanced practice nurses, registered nurses, social workers, dieticians, therapists and other integrated health service providers) who deliver evidence-based prevention, health promotion and management of chronic disease

A Look toward the Future—Sooner, Rather Than Later

Increasing numbers of persons are either uninsured or underinsured, and the system's inability to contain cost continues to place more people at risk when illness or disability occurs. Health

equity for underserved populations should be addressed effectively and quickly. Health policy and health spending have been dominated thus far by a focus on payment for medical treatment. More attention needs to be drawn to public policy and legislative initiatives that promote health within a person-centered, systems-oriented and coordinated approach.

Wisconsin nurses believe in ensuring access to the right care at the right time, in the right place and by the right provider. We believe that focusing on these four basic tenets – illness and disease prevention and health promotion, health literacy, patient safety, and coordinate chronic disease management, will improve the health status of individuals and society. Application of these principles will give people of all ages, race and socio-economic status improved health. For the people of Wisconsin, their productivity will be enhanced along with the realization that there are opportunities for a better quality of life. Health for all can be optimized by fully using the following strategies:

- Providing health promotion education in early childhood to develop behaviors that will be practiced throughout the life span
- Improving health literacy will support individual accountability for good health practices
- Promoting patient safety through an interdisciplinary model of care
- Partnering with system organizations to design products to improve coordination and quality of health care
- Improving health care provider safety through the development of effective equipment and use of technology
- Integrating evidence-based protocols in the management of disease to promote high quality, cost-efficient and safe health outcomes

We are all participants in our health care system and have responsibility for the future and evolution of the health of our society. Wisconsin's seventy-six thousand registered nurses are committed to working with partners to reform healthcare in Wisconsin.

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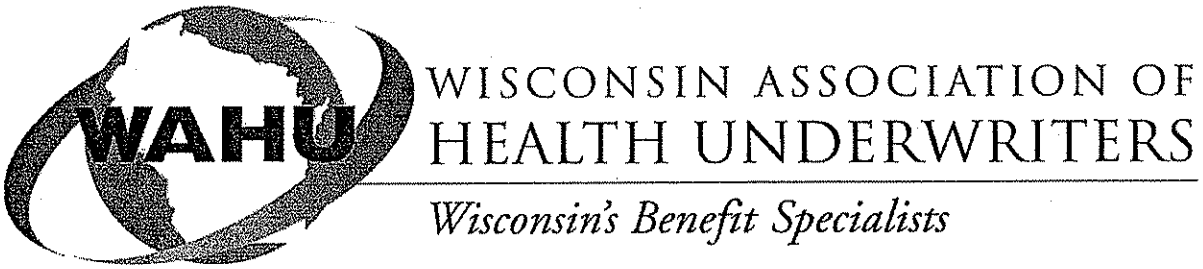
Committee Clerk



The members of the Wisconsin Association of Health Underwriters (WAHU) and National Association of Health Underwriters (NAHU) are comprised of insurance professionals involved in the sale and service of health benefits, long-term care benefits, and other related products, serving the insurance needs of over 100 million Americans. We have almost 18,000 members around the country and over 600 members here in Wisconsin. Our membership is primarily made up of insurance agents that work directly for and with the consumers of health care. Since our number one concern is our customers, we consider ourselves to be consumer advocates and look at how any legislation or issue will affect these customers.

We would like to thank you for the opportunity to provide some comments on the insurance market reforms that are included in Governor Doyle's 2009-11 Biennial Budget Bill.

The Wisconsin Association of Health Underwriters appreciates the efforts being made to provide reforms to our current market place that would make purchasing and utilizing health insurance easier for our members' clients. Our member's number one concern for their clients is the cost of insurance, which we believe is a direct result of the cost of health care. While we sometimes get concerned about insurance reforms and the effect that will have on insurance premiums for Wisconsin consumers, we also understand that some reforms would have less impact on premiums than other. Where such reforms can be balanced with minimal impact to increases in insurance premiums, we support those reforms.

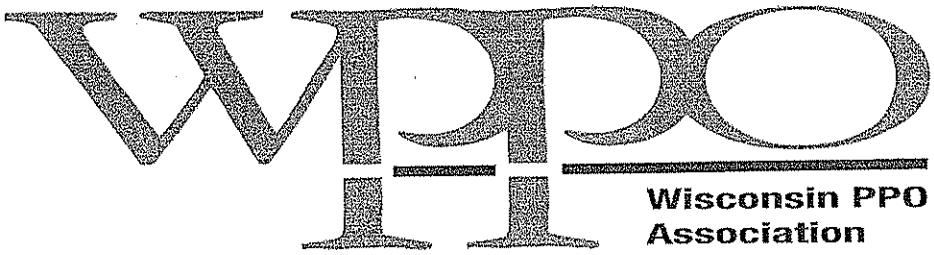
The following are provisions that we would like to address with you, and to offer suggestions that we think will maintain the general purpose of the reform, but that would balance the measure to potentially reduce the risk if unnecessarily increasing premiums for consumers.

Health Insurance Coverage Requirements for Dependents – Information obtained from NAHU shows that many states have attempted to increase the age of dependent coverage. For the most part, there does not appear to be any drastic change in premium as a result of increasing these age limits. However, in nearly all instances, the criteria for coverage remains the ability for the parents to claims the dependent on their IRS tax forms. There are several concerns if coverage is not affiliated with IRS dependent status, most importantly the tax implications on both the employer and employee. We ask that you consider changing this provision to only require insurers to cover these dependents through the age of 26 if such dependent is listed as a dependent on the parent(s) IRS tax return.

Independent External Review of Coverage Denials – WAHU supported the original Independent External Review (IER) law as it provided needed consumer protections to our members' clients. Expanding this law to include both denials based on pre-existing conditions and rescissions could provide additional consumer protections but we are concerned that the language as written could cause insurer's to increase premiums. First, we are very concerned that the decision of the IER will not be binding on the insured, as it is under our current IER law. Our understanding is that the current IER process in Wisconsin is working effectively and we would be opposed to expanding IER if this requirement is removed. We strongly recommend that language is amended to ensure that the decision of the IER is binding on both the insured and insurer. Lastly, we are concerned that this provision would be applied to short term major medical policies. . These policies have different purposes than does permanent individual or group coverages, and this requirement will likely cause a significant increase in premiums if insurers have to pay for each of these reviews. We strongly recommend this provision be amended to exclude IER from any short term major medical policies.

Pre-Existing Condition Exclusions for Individual Health Insurance Policies – We support this provision, but would like to echo the same concern we previously raised. We want to be sure this provision does not affect short term major medical policies. It would be a disservice to consumers if either of these provisions caused insurers to discontinue selling these types of policies.

Uniform Application for Individual Health Insurance Policies – WAHU was one of the major supporters of our states Uniform Employee Application. We still support the concept today, but do have concerns as to whether the application in its current form is actually making easier and more understandable for consumers. We support format suggestions so that each insurer application have similar looks, but are concerned that developing specific underwriting questions that can only be used by each insurer will lead to confusion and the development of a more lengthy application. We would suggest that the OCI provide "guidelines" to insurers on both the underwriting questions and the format of the application, rather than having the OCI develop a set of specific underwriting questions.



Suggested Changes to Insurance Market Reforms
Governor's Budget Proposal & Provisions in
Senate Bill 70
Senate Bill 71
Senate Bill 72

HEALTH INSURANCE COVERAGE COVERAGE REQUIREMENTS FOR DEPENDENTS

SENATE BILL 70 - WPPO does not oppose the concept of providing coverage to older dependents, but we do have concern about these dependents coming in and out of the parent's plan without any requirement of prior coverage. In addition, we do not believe the intent of the law was to guarantee issuance to these older dependents. We would like to offer suggested language changes to address these concerns. Some of the specific language is from New Jersey that would expand coverage to older dependents, but would address the concerns raised by the industry.

Suggested Changes:

To address the concern we have on interpreting the provision to require guarantee issue of coverage to dependents, we suggest the following suggestion under the new Section 632.895(14m):

"Subject to par. (b) every disability insurance policy, and every self-insured health plan of the state or a county, city, town, village, or school district, that provides coverage for a person as a dependent of an insured shall extend ~~provide~~ dependent coverage for a child of an insured."

To address the concerns of continuous coverage, we would like to offer the similar statutory language from New Jersey.

Coverage for certain dependents until age 27 by group health insurance policy.

4. a. As used in this section, "dependent" means an insured's child by blood or by law who:

(1) is 26 years of age or younger;

(2) is unmarried;

(3) has no dependent of his own;

(4) is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education; and

(5) (a) is not actually provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, Pub.L.74-271 (42 U.S.C. s.1395 et seq.) at the time dependent coverage pursuant to this section begins or will begin; and

(b) there is evidence of prior, creditable coverage or receipt of benefits under a benefits plan or by law as set forth in subparagraph (a) of this paragraph.

b. (1) A group health insurance policy that provides coverage for an insured's dependent under which coverage of the dependent terminates at a specific age on or before the dependent's 27th birthday, and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Insurance on or after the effective date of this section shall, upon application of the dependent as set forth in subsection c. of this section, provide coverage to the dependent after that specific age, until the dependent's 27th birthday.

(2) Nothing herein shall be construed to require:

(a) coverage for services provided to a dependent before the effective date of this section of; or

(b) that an employer or other group policyholder pay all or part of the cost of coverage for a dependent as provided pursuant to this section.

c. (1) A dependent covered by an insured's policy, which coverage under the policy terminates at a specific age on or before the dependent's 27th birthday, may make a written election for coverage as a dependent pursuant to this section, until the dependent's 27th birthday:

(a) within 30 days prior to the termination of coverage at the specific age provided in the policy;

(b) within 30 days after meeting the requirements for dependent status as set forth in subsection a. of this section, when coverage for the dependent under the policy previously terminated; or

(c) during an open enrollment period, as provided pursuant to the policy, if the dependent meets the requirements for dependent status as set forth in subsection a. of this section during the open enrollment period.

INDEPENDENT REVIEW OF COVERAGE DENIAL DETERMINATIONS AND RESCISSIONS

SENATE BILL 72 - We do have some concerns on expanding IER in a few areas. The first is that the provision should not apply to short term major-medical plans. The second area of concern is allowing IER on pre-existing condition denials for each claim, rather than for an episode of care or for a diagnosis.

Suggested Changes:

To address the concern of short term major medical policies, we would like to offer the following definition used in Connecticut:

This provision does not apply to short term major medical plans, defined as short-term health insurance issued on a nonrenewable basis with a duration of twelve months or less.

To address the concern of pre-existing condition denials, we would like to suggest that you include the following additional language:

An Independent External Review of a pre-existing condition denial determination shall include a review of the actual diagnosis and weather or not the condition manifested itself prior to the effective date of the policy. It shall not review the underlying claims submitted for that diagnosis.

INDIVIDUAL HEALTH POLICIES -- MODIFICATIONS AT RENEWALS

SENATE BILL 71 - Of concern with this provision is the current practice by insurers relating to closed blocks. While we support your desire for change to ensure competitive insurance premiums for all, we believe the language as written will dramatically increase premiums for individuals in Wisconsin. The NAIC commissioned a study by the American Academy of Actuaries that looked at a proposal for closed blocks of business that would have had similar results as this proposal. It was shown that such an approach would increase health insurance premiums in the individual market by at least 50%.

Suggested Changes:
To address our concern, we would like to offer language used in Arkansas that addresses closed block and a solution that would have much less of a premium impact that as currently written. We would suggest you delete the provision as written and substitute it with the following language:

Plan modifications
632.7495 (1) (b) 2. The insurer shall, at the request of the insured individual, do the following:

a. Provide access to any available lower cost benefit plan with reduced benefits and/or a higher deductible, without subjecting the individual covered under the individual health benefit plan to

additional underwriting.

b. Provide coverage to the insured individual under a different individual health benefit plan offered by the insurer, subject to additional underwriting.

Closing a block of health insurance business

(a) As used in this section:
(1) " Block of business" means a health benefit plan that includes distinct benefits, services, and terms issued by a carrier to one (1) or more individuals;
(2) " Closed block of business" means a block of business that a carrier ceases to actively sell to new applicants; and
(3)(A) "Health benefit plan" or "plan" means an individual expense-incurred hospital, medical, surgical, or dental policy, nonprofit health care corporation certificate, or health maintenance organization contract. Health benefit plan does not include accident-only, credit, or disability income insurance; long-term care insurance; coverage issued as a supplement to liability insurance; coverage only for a specified disease or illness; worker's compensation or similar insurance; or automobile medical-payment insurance.
(b) A carrier must pool a block of business after it has been closed for five years with all other blocks of business that have been closed for at least five years for the purpose of determining the percentage premium rate increase of any health benefit plan within the closed block of business.

INDIVIDUAL HEALTH INSURANCE POLICIES -- PREEXISTING CONDITION EXCLUSIONS

SENATE BILL 72 - The only concern we have with this provision is that it should not be applied to short term major medical policies. Again, we would suggest using a definition from Connecticut.

Suggested Changes:
We would like to offer the following definition used in Connecticut:

This provision does not apply to short term major medical plans, defined as short-term health insurance issued on a nonrenewable basis with a duration of twelve months or less.

INDIVIDUAL HEALTH INSURANCE POLICIES -- UNIFORM APPLICATION

SENATE BILL 71 - We do have a concern with this provision as written. We are concerned that it will lead to the development of much longer application that what the market currently uses and therefore will be more confusing for consumers, rather than less confusing. We would suggest we use some of the similar language found in the California statutes as it relates to individual applications.

Suggested Changes:

Delete this provision and create the following language:

601.41 (10) APPLICATION FOR INDIVIDUAL MAJOR MEDICAL HEALTH INSURANCE POLICIES.

(a) The commissioner shall by rule develop for use by insurers a uniform application for individual major medical health insurance policies. The commissioner shall also by rule prescribe the format for the uniform application, which may not exceed 10 pages in length. The commissioner shall consult with insurers when developing the uniform application.

(b)Insurers shall have the option of accepting the uniform application or may use a company-specific application for individual major medical health insurance policies. All individual major medical health insurance policy applications that are not uniform applications must be approved for use by the commissioner. The insurance commissioner may develop rules to ensure that individual health insurance policy applications are clear and easy to understand.

(c) The commissioner shall also develop by rule a pool of health questions for the uniform application and insurers using the uniform application can only use the approved health questions in their application. Health insurers may submit additional questions to be used with the uniform applications, for approval by the commissioner. The commissioner shall consult with insurers when developing the pool of questions for the uniform application.

(d) The use of an individual major medical health insurance policy application does not limit the ability of an insurer to request or obtain additional information for underwriting purposes.

(e) The commissioner shall publish a notice in the Wisconsin Administrative Register stating the effective date of the rules promulgated under paras. (a) (b) and (c). Insurers who choose to accept the uniform application shall notify the commissioner in writing. The commissioner also shall develop rules to allow electronic use of the uniform application. The effective date for electronic use of the application will be no sooner than one-year following the effective date of the uniform application.

(f) For purposes of this subsection, an individual major medical health insurance policy includes health coverage provided on an individual basis. An individual major medical health insurance policy shall not include short-term limited duration health policy or certificate, limited health policy or certificate marketed on a basis other than major or comprehensive medical, an individually underwritten medical plan marketed or sold only to students, accident-only coverage, hospital or sickness fixed indemnity plans, specified disease or critical illness plans, individually underwritten medical plans not marketed as major medical coverage, credit health insurance, dental coverage or disability income insurance.

We would again like to thank you for allowing us to provide our comments and suggests and would welcome the opportunity to discuss these suggestions further. Please let me know if you have any questions or comments on our suggested changes.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

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Testimony of Eileen Mallow, Assistant Deputy Commissioner
To the Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief and Revenue
Senate Bill 72
April 22, 2009

Chairman Erpenbach and Members of the Committee:

Thank you for the opportunity to testify in support of Senate Bill 72, relating to portability under group health benefit plans and independent review of insurance policy rescissions and preexisting condition exclusion denials under group and individual benefit plans.

In light of current economic pressures and the challenges some face in accessing health care coverage, business practices in the individual health insurance market with respect to preexisting condition exclusions and rescissions is increasingly gaining more attention. For example, United States Representative Henry Waxman, Chairman of the House Committee on Oversight and Government Reform, held a hearing in July 2008 focused on the practice of rescission in the individual health insurance market. In October 2008, he reached out to states requesting information on state regulatory oversight of rescissions in an effort to further the Committee's understanding of market practices.

The Office of the Commissioner of Insurance (OCI) received 343 complaints relating to preexisting conditions and recessions from January 2006 through March 2009. As a result of OCI's experience with such complaints, as well as those in several other state insurance departments, the National Association of Insurance Commissioners continues work on a national survey regarding individual health insurer business practices with respect to recession and exclusion decisions. The goal is to better understand current practice and its impact on consumers.

The requirement in SB 72 that insurers issuing individual health benefit plans report to the Commissioner annually the number of benefit plans issued and the number of plans where the insurer initiated or completed a cancellation or rescission, will help in understanding market practices.

In an effort to empower consumers impacted by preexisting condition determinations and rescissions, SB 72 expands independent review options under current law to include a preexisting condition exclusion denial determination and the rescission of a policy. Therefore, individuals who are denied coverage for these reasons can pursue third party review by an independent review organization (IRO), after an internal grievance with the insurance company is complete. Independent review organizations are certified by the Commissioner and must demonstrate that they are unbiased.

IRO's must be recertified on a biennial basis to continue to provide services. There are currently six certified IRO's. SB 72 specifically requires that at least one independent review organization is certified to effectively provide reviews relating to preexisting condition exclusion denial determinations and rescissions.

Lastly, SB 72 improves portability in the individual health care market. Currently, when determining how long preexisting condition exclusion periods may be imposed under new health insurance coverage, a person must be given credit for the time during which he or she previously had health insurance coverage. SB 72 allows past coverage to be applied if new coverage is obtained within 90 days. Current law allows for a 63 day window. The additional month provided in SB 72 allows individuals more time to assess their situation and shop for new coverage.

Thank you again for the opportunity to testify in support of SB 72. I am happy to answer any questions.

WNA
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TO: Chairperson Jon Erpenbach and Members of the Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

FROM: Gina Dennik-Champion, MSN, RN, MSHA
Executive Director, Wisconsin Nurses Association

DATE: April 22, 2009

RE: Support of SB 71– Relating to Preexisting Condition Exclusions, Modifications at Renewal, And Establishing a Standard Application for Individual Health Benefit Plans and Granting Rule-Making Authority

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Good morning Chairperson Erpenbach and members of the Senate Health Committee. My name is Gina Dennik-Champion, I am a registered nurse and I am here today representing the Wisconsin Nurses Association (WNA). WNA is the professional association for all RNs in Wisconsin. As a professional nursing association, we collectively and collaboratively advocate for access to comprehensive quality health care services for all people. This in turn provides the person an increased opportunity for maintaining health and sustaining a life of quality.

Thank you for allowing me the opportunity to share WNA's support of SB 71 and the companion bill AB 100 – Relating to Preexisting Condition Exclusions, Modifications at Renewal, and Establishing a Standard Application for Individual Health Benefit Plans and Granting Rule-Making Authority. WNA extends appreciation to you, Vinehout, for sponsoring this legislation and the members of this committee who are supporting this legislation.

For background purposes, WNA would like to share that we are members of a health care reform discussion group that was facilitated by Senator Kathleen Vinehout and Representative Donna Seidel. This group consists of professional health care practitioners, health care providers, insurance companies, and other advocacy groups. The group discussed the barriers that exist for consumers in obtaining health insurance and the changes needed so that access to health care could be achieved. WNA is very appreciative of Senator Vinehout and Representative Seidel in bringing this group together, as we now have an opportunity for removing some of these barriers.

WNA has held a long-standing interest in health care reform. WNA, along with other members of the Wisconsin Nursing Coalition, developed a document in 1999 which has recently been revised that describes professional nursing's opinions and recommendations for health care reform. This document, *The Wisconsin Community of Nursing Agenda for Healthcare Reform* (January 2009), describes the need for a reformed health care system. WNA, as part of the nursing community, remains optimistic that true health care reform will occur, as we cannot as a society continue to have:

- 350,000 persons go without care or enter the system sicker, at higher cost entry points;
- Limited access to health care in rural communities and dense urban areas;
- Decreased personal incomes as more out-of-pocket health care costs rise;
- A rapidly growing aging and culturally diverse population;
- Health disparities among underserved populations;
- Health care workforce shortages;
- Annual double digit increases in health costs;
- Decreased profits for business as health insurance costs rise;
- Gaps, fragmentation and duplication in delivery of services;
- A "system" that is complex, confusing and wasteful; and
- Environmental practices that negatively impact healthy living.

As we wait for health care reform to occur nationally and in Wisconsin, we cannot ignore the real issues that are impacting real people in the pursuit of health care coverage for all. SB 71 addresses the issues and limitations on individual health insurance by limiting the preexisting condition exclusion from two years to one year. By doing this, Wisconsin joins 23 other states with a one-year preexisting policy. In addition, SB 71 requires that a physician must previously diagnose the preexisting condition and the exclusion period for preexisting conditions cannot exceed one year. Some insurance companies now deny payment for treatments of existing diseases because the patient "should have known" about the problem earlier.

SB 71 also provides the consumer with choices at the time of policy renewal by allowing the consumer to change coverage to a comparable product currently offered by their insurer, or modify their existing coverage. These choices may include additional coverage, more limited benefits or higher deductibles. In addition, the consumer shall not be subject to any additional underwriting or any new preexisting conditions exclusion that did not apply to his or her original coverage.

Lastly, SB 71 gives the Commissioner of Insurance the authority to establish uniform insurance application with standard underwriting questions. Having standardized questions is no different than the process used for group health insurance applications. This policy supports fairness.

WNA encourages the passing of SB 71 as it addresses those instances when patients are in need of health care insurance the most. Without it we see patients using their credit cards to pay for their needed care, selling their home and valued possessions and/or declaring personal bankruptcy. Given the current economic crisis, situations like this have a high probability of increasing. People should not have to become destitute to have access to health care. Health care organizations should not have to recoup their costs on the back of a person who cannot purchase a health insurance policy because of a preexisting condition.

Thank you for providing WNA the opportunity to present our support of SB 71.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

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Testimony of Eileen Mallow, Assistant Deputy Commissioner
To the Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief and Revenue
Senate Bill 71
April 22, 2009

Chairman Erpenbach and Members of the Committee:

Thank you for the opportunity to testify in support of Senate Bill 71, relating to preexisting condition exclusions, modifications at renewal and establishing a standard application for individual health benefit plans.

The Office of the Commissioner of Insurance (OCI) received 343 complaints relating to preexisting conditions and rescissions from January 2006 through March 2009. As a result of OCI's experience with such complaints, as well as those in several other state insurance departments, the National Association of Insurance Commissioners continues work on a national survey regarding individual health insurer business practices with respect to rescission and exclusion decisions. The goal is to better understand current practice and its impact on consumers.

One evident problem is the practice of "post claims underwriting," or retroactive denial of coverage after a claim is filed. Modifications proposed in SB 71 will help to decrease this practice and encourage individual health insurers to perform thorough medical underwriting prior to issuing a policy. Such proposed modifications also increase access to medical treatment that might not be available to insureds under current law due to the current definition of preexisting condition applied to individual coverage and the 2 year exclusion period. These modifications include:

- Decreasing the time in which an insurer may impose a preexisting condition exclusion from 2 years to 1 year. According to the Kaiser Family Foundation, 23 states use 1 year. Current state law allows for a 1 year preexisting condition period for group health insurance plans.

- Limiting to 1 year the timeframe with respect to how far back into an individual's medical history an insurer can look for the purpose of determining that a condition is preexisting. There is currently no limit for such a "look back." 26 states use a 1 year or less "look back" period.

- Requiring that a preexisting condition include a condition for which medical advice was given or treatment recommended. This is referred to as an "objective standard." Current law uses a "prudent person" standard which relies on

conditions that were never diagnosed, but rather symptoms present that a prudent person would have sought medical advice or treatment.

SB 71 also allows individuals, at the time of policy renewal, to receive coverage under a different but comparable policy offered by the insurer. The insurer cannot apply additional underwriting for the new coverage. This will allow individuals to move out of closed blocks of business and into open blocks where they may experience lower rates. Another option provided under the bill is for insureds to request, at the time of renewal, that the benefits or deductible level be modified. This allows an insured more flexibility to obtain coverage that meets their medical and financial needs.

Finally, SB 71 directs OCI to craft a uniform application for individual health insurance policies. Such an application form will ease the application process for consumers, in particular those applying for coverage from more than one insurer. I am committed to developing such an application with interested parties at the table providing input into the details of the final document. It is worth noting that there is currently a small employer uniform employee application for group heath insurance.

OCI supports modifications to SB 71 that reflect the short term health insurance changes the Assembly Health Committee adopted to AB 100 last week. These include:

- Prohibiting coverage under a short term health insurance policy from exceeding 12 months.
- Restricting short term polices to a consecutive coverage period of no more than 18 months.
- Applying the 12 month "look forward" limit to short term policy pre-existing condition exclusion periods.
- Applying the objective standard for determining whether a condition is pre-existing.
- Exempting short term policies from the 12 month "look back" restriction.
- Requiring portability between consecutive short term policies issued by the same insurer.
- Requiring OCI to promulgate rules governing sales disclosures for short term policies.

In summary, SB 71 will increase consumer protection and confidence that coverage will be available when it is needed most. It also will bring Wisconsin law pertaining to individual health insurance coverage in line with other states and current Wisconsin law with respect to group health insurance coverage.

Thank you for the opportunity to testify in support of SB 71 today. I welcome any questions.

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TO: Senate Committee on Insurance
FROM: Advocacy and Benefits Counseling for Health, Inc.
By Atty Bobby Peterson
DATE: April 21, 2009
RE: Senate Hearing on SB 71

Advocacy and Benefits Counseling for Health, Inc. (ABC for Health) is a Wisconsin-based nonprofit public interest law firm dedicated to ensuring health care access for children and families, particularly those with special needs or who are at risk. ABC for Health's mission is to provide health care consumers with the information, advocacy tools, legal services, and expert support they need to navigate through America's complex and confusing health care financing system. ABC for Health has several concerns regarding the enforcement (or lack there of) of insurance rules in Wisconsin. Our agency's experience over the last 15 years and my 20 years of specializing in legal representation for clients with insurance and coverage issues provides the perspective for our following suggestions on legislative reforms for the benefit of Wisconsin consumers.

First, ABC for Health is encouraged that SB 71 shortens the amount of time that insurance companies can look back for preexisting conditions from 2 years to 12 months. SB 71 Section 7 says that an insurer "may not define a preexisting condition 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 coverage." Insurance companies must not have added incentives to deny, delay or curtail health coverage to anyone they ***believe*** have pre-existing conditions such as heart disease, diabetes, cancer, etc. People with serious conditions struggle to find individual insurance or to afford the higher premiums they would be charged. Survey results from The Commonwealth Fund show that 21% of working-age adults who looked into individual market health insurance were turned down, charged a higher price for a pre-existing condition, or had their pre-existing condition excluded from coverage. Tough economic times are aggravating the situation, as more people unexpectedly find themselves without a job and the healthcare coverage they may have taken for granted.

The way SB 71 defines Preexisting Condition also helps with existing, overly-restrictive definitions. Insurance companies have become accustom to cutting off the definition of "preexisting condition" in their policies. An example we have seen in our work includes a common scenario of an individual seeking treatment, getting a wrong diagnosis, and having that diagnosis treated as a preexisting condition.

SB71 needs modifications that would make the independent review process truly fair for consumers. SB71 will only be as effective as the enforcement power behind the law. Currently, the law does not include a legal review of documents that are submitted as part of the independent review process. This is a grave oversight that can be costly to health care consumers and is an unwarranted gift to insurers in Wisconsin. State and federal insurance law under pin most plan contracts. Therefore legal expertise and interpretation is required to review and correctly interpret policy provisions. Wisconsin law construes ambiguous contract language in policies in favor of consumers. Other Wisconsin legal doctrine holds that insurance companies must address the reasonable expectations of insurance coverage by consumers. Without lawyers, the risk is that "independent reviewers" with medical knowledge but inadequate legal knowledge and training, will misconstrue the terms of the contract to the detriment of the consumer.

Going hand in hand with SB71, in the context of pre existing conditions, consumers are not supposed to be the absolute guarantors of their health. Yet these important principles of Wisconsin contract law are lost without the input of review and analysis by an independent legal counsel.

In tandem with SB 71, we recognize SB 72's expansion of independent review to include all types of coverage denials. Again this expansion will be strengthened with legal review in the independent review process. We support the bills provisions that permit insured to commence a civil action against a company during or after the independent review process

The Senate Committee on Insurance is considering SB 71 at a time of change. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) protects individual's right to maintain group insurance coverage for a limited time, regardless of pre-existing conditions or emerging new health conditions. COBRA, however, is notoriously expensive. New governmental subsidies have helped to reduce COBRA premiums by 65% for eligible people. But once COBRA is exhausted, the initial private market problem remains. Wisconsin also has a high risk insurance sharing pool. Unfortunately, while these programs are well-intentioned safety nets, many people just can't afford them. The state will be footing the bill for the numerous individuals that have no private insurance as summer approaches. The implementation of BadgerCare Plus Core Plan for Adults with No Dependent Children begins Enrollment on June 1, 2009, with a July 1, 2009 implementation date. As private insurers maintain long look-back periods for pre-existing conditions, Wisconsin will find itself with BadgerCare Plus paying the price of the private insurance exclusions.

Other immediate reforms should be under active consideration. The Wisconsin State Legislature must stop the give-a-way of Wis. Stat. § 631.36(2)(c), which allows insurance companies to rescind coverage to new policyholders for any reason within the first 60 days of coverage. Not only is this "bait and switch" law grossly unfair to consumers, but it increases the already-serious problem of uninsured citizens in Wisconsin. It defies the basic tenets of contract law, in which both parties are bound to an agreement unless the other commits

a material breach of the contract. § 631.36(2)(c) leaves consumers at the mercy of insurers to unilaterally terminate coverage without explanation.

Lastly, we recommend that insurance companies be required to provide all policy information in electronic format. Having policies digitized and available in PDF format will eliminate many misunderstandings about policy terms and will ensure that consumers, in most cases, can quickly access the most current information pertaining to their coverage. Thank you for your attention to

Please do not hesitate to contact ABC for Health if we can be of further assistance or you would like to discuss these issues further.

Sincerely,
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HIRSP AUTHORITY

Testimony to Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue
Presented by Amie Goldman, CEO HIRSP Authority
April 22, 2009

Senate Bill 73

Under current law, the lifetime benefit available to Health Insurance Risk-Sharing Plan Authority (HIRSP) policyholders is $1,000,000. In October 2008, the HIRSP Board of Directors voted unanimously to seek a statutory change that would allow the Board of Director's additional flexibility to adjust the lifetime maximum on HIRSP policies to keep pace with medical inflation and the individual market.

In 2007 and 2008, three policyholders reached the lifetime maximum and lost their HIRSP coverage. Currently, there are three policyholders who have reached 75% of their lifetime maximum. For those who exceed this benefit, there are very few options. Some may qualify for Medicare if their medical condition could be considered a disability, but more likely these individuals find themselves uninsured.

The HIRSP Authority Board of Directors has noted that the rising cost of health care has reduced the value of a $1,000,000 maximum over time and that as the insurer of last resort HIRSP should offer higher levels of coverage to better serve the state's high-risk population. The current limit is also out of line with the commercial individual market.

Based on a December 2007 report from America's Health Insurance Plans (AHIP), the average lifetime maximum in force for policies (weighted based on enrollment) included in the report was approximately $3.1 million for HMO plans, $3.7 million for indemnity plans, $4.2 for PPO/POS plans and $4.5 million for HSA plans in the individual market. Approximately one-third of state high-risk pools also have lifetime benefits that exceed $1 million.

The Authority's actuary suggests that increasing the lifetime maximum benefit to between $2 and $5 million would result in a less than 1% increase in HIRSP premiums.

The Board of Directors fully supports Senate Bill 73 and looks forward to its enactment.

Senate Bill 74

Until passage of 2005 Wisconsin Act 74 (Act 74), only one letter of rejection based in whole or in part on medical underwriting was required. Effective July 1, 2006, Act 74 increased the requirement to two letters of rejection. Since that time, the HIRSP Authority has heard from a handful of legislators, insurance agents and Wisconsin residents that the requirement of two letters creates an additional administrative and cost barrier to potential applicants and is unnecessary.

At the February 2009 meeting of the HIRSP Authority Board of Directors, the Board reviewed and discussed the proposed statutory change included in Assembly Bill 112 that would reduce the number of rejection letters required for HIRSP eligibility from two to one.

The Board voted unanimously to support Senate Bill 74 recognizing that it could improve access to HIRSP for eligible persons without a negative impact to the plan.

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