



State of Wisconsin
2017 - 2018 LEGISLATURE

LRBa2662/1
TJD:all

**SENATE AMENDMENT 2,
TO SENATE SUBSTITUTE AMENDMENT 2,
TO ASSEMBLY BILL 365**

December 4, 2018 - Offered by Senators ERPENBACH, SHILLING, SCHACHTNER, WIRCH, MILLER, L. TAYLOR, JOHNSON, VINEHOUT, CARPENTER, LARSON, FROSTMAN, RINGHAND, RISSER, HANSEN and BEWLEY.

1 At the locations indicated, amend the substitute amendment as follows:

2 **1.** Page 1, line 3: delete “coverage of individuals with preexisting conditions”
3 and substitute “Medicaid expansion and eligibility for BadgerCare, lifetime and
4 annual limits, preventive services, essential health benefits, guaranteed issue, and
5 preexisting conditions under health insurance policies and plans and requiring the
6 exercise of rule-making authority”.

7 **2.** Page 2, line 1: delete the material beginning with that line and ending with
8 page 6, line 2, and substitute:

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

10 40.51 (8) Every health care coverage plan offered by the state under sub. (6)
11 shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.728, 632.746
12 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853,

1 632.855, 632.867, 632.87 (3) to (6), 632.883, 632.885, 632.89, 632.895 (5m) and (8) to
2 (17), and 632.896.

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

4 40.51 **(8m)** Every health care coverage plan offered by the group insurance
5 board under sub. (7) shall comply with ss. 631.95, 632.728, 632.746 (1) to (8) and (10),
6 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.867,
7 632.883, 632.885, 632.89, and 632.895 ~~(11)~~ (8) and (10) to (17).

8 **SECTION 3.** 49.45 (23) (a) of the statutes is amended to read:

9 49.45 **(23)** (a) The department shall request a waiver from the secretary of the
10 federal department of health and human services to permit the department to
11 conduct a demonstration project to provide health care coverage to adults who are
12 under the age of 65, who have family incomes not to exceed ~~100~~ 133 percent of the
13 poverty line ~~before application of the 5 percent income disregard under 42 CFR~~
14 435.603 (d), except as provided in s. 49.471 (4g), and who are not otherwise eligible
15 for medical assistance under this subchapter, the Badger Care health care program
16 under s. 49.665, or Medicare under 42 USC 1395 et seq.

17 **SECTION 4.** 49.471 (1) (cr) of the statutes is created to read:

18 49.471 **(1)** (cr) “Enhanced federal medical assistance percentage” means a
19 federal medical assistance percentage described under 42 USC 1396d (y) or (z).

20 **SECTION 5.** 49.471 (4) (a) 4. b. of the statutes is amended to read:

21 49.471 **(4)** (a) 4. b. ~~The~~ Except as provided in sub. (4g), the individual’s family
22 income does not exceed ~~100~~ 133 percent of the poverty line ~~before application of the~~
23 ~~5 percent income disregard under 42 CFR 435.603 (d)~~.

24 **SECTION 6.** 49.471 (4g) of the statutes is created to read:

1 49.471 (4g) MEDICAID EXPANSION; FEDERAL MEDICAL ASSISTANCE PERCENTAGE. (a)
2 For services provided to individuals described under sub. (4) (a) 4. and s. 49.45 (23),
3 the department shall comply with all federal requirements to qualify for the highest
4 available enhanced federal medical assistance percentage. The department shall
5 submit any amendment to the state medical assistance plan, request for a waiver of
6 federal Medicaid law, or other approval request required by the federal government
7 to provide services to the individuals described under sub. (4) (a) 4. and s. 49.45 (23)
8 and qualify for the highest available enhanced federal medical assistance
9 percentage.

10 (b) If the department does not qualify for an enhanced federal medical
11 assistance percentage, or if the enhanced federal medical assistance percentage
12 obtained by the department is lower than printed in federal law as of July 1, 2013,
13 for individuals eligible under sub. (4) (a) 4. or s. 49.45 (23), the department shall
14 submit to the joint committee on finance a fiscal analysis comparing the cost to
15 maintain coverage for adults who are not pregnant and not elderly with family
16 incomes of up to 133 percent of the poverty line to the cost of limiting eligibility to
17 those adults with family incomes of up to 100 percent of the poverty line. The
18 department may reduce income eligibility for adults who are not pregnant and not
19 elderly from family incomes of up to 133 percent of the poverty line to family incomes
20 of up to 100 percent of the poverty line only if this reduction in income eligibility
21 levels is approved by the joint committee on finance.

22 **SECTION 7.** 66.0137 (4) of the statutes, as affected by 2017 Wisconsin Act 30,
23 is amended to read:

24 66.0137 (4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or
25 a village provides health care benefits under its home rule power, or if a town

1 provides health care benefits, to its officers and employees on a self-insured basis,
2 the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),
3 632.728, 632.746 (1) and (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853,
4 632.855, 632.867, 632.87 (4) to (6), 632.883, 632.885, 632.89, 632.895 ~~(9)~~ (8) to (17),
5 632.896, and 767.513 (4).

6 **SECTION 8.** 120.13 (2) (g) of the statutes, as affected by 2017 Wisconsin Act 30,
7 is amended to read:

8 120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss.
9 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.728, 632.746 (1) and (10) (a) 2. and (b)
10 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (4) to (6), 632.883,
11 632.885, 632.89, 632.895 ~~(9)~~ (8) to (17), 632.896, and 767.513 (4).

12 **SECTION 9.** 185.983 (1) (intro.) of the statutes is amended to read:

13 185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a
14 cooperative association organized under s. 185.981 shall be exempt from chs. 600 to
15 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44,
16 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93,
17 631.95, 632.72 (2), 632.728, 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798,
18 632.85, 632.853, 632.855, 632.867, 632.87 (2) to (6), 632.883, 632.885, 632.89,
19 632.895 (5) and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645,
20 and 646, but the sponsoring association shall:

21 **SECTION 10.** 609.713 of the statutes is created to read:

22 **609.713 Essential health benefits.** Defined network plans and preferred
23 provider plans are subject to s. 632.895 (14m).

24 **SECTION 11.** 609.845 of the statutes is created to read:

1 **609.845 Lifetime and annual limits.** Limited service health organizations,
2 preferred provider plans, and defined network plans are subject to s. 632.883.

3 **SECTION 12.** 609.847 of the statutes is created to read:

4 **609.847 Preexisting condition discrimination prohibited.** Limited
5 service health organizations, preferred provider plans, and defined network plans
6 are subject to s. 632.728.

7 **SECTION 13.** 609.896 of the statutes is created to read:

8 **609.896 Preventive services.** Defined network plans and preferred provider
9 plans are subject to s. 632.895 (13m).

10 **SECTION 14.** 625.12 (1) (a) of the statutes is amended to read:

11 625.12 (1) (a) Past and prospective loss and expense experience within and
12 outside of this state, except as provided in s. 632.728.

13 **SECTION 15.** 625.12 (1) (e) of the statutes is amended to read:

14 625.12 (1) (e) Subject to ~~s.~~ ss. 632.365 and 632.728, all other relevant factors,
15 including the judgment of technical personnel.

16 **SECTION 16.** 625.12 (2) of the statutes is amended to read:

17 625.12 (2) CLASSIFICATION. ~~Risks~~ Except as provided in s. 632.728, risks may
18 be classified in any reasonable way for the establishment of rates and minimum
19 premiums, except that no classifications may be based on race, color, creed or
20 national origin, and classifications in automobile insurance may not be based on
21 physical condition or developmental disability as defined in s. 51.01 (5). Subject to
22 ~~s.~~ ss. 632.365 and 632.728, rates thus produced may be modified for individual risks
23 in accordance with rating plans or schedules that establish reasonable standards for
24 measuring probable variations in hazards, expenses, or both. Rates may also be
25 modified for individual risks under s. 625.13 (2).

1 **SECTION 17.** 625.15 (1) of the statutes is amended to read:

2 625.15 (1) RATE MAKING. ~~An~~ Except as provided in s. 632.728, an insurer may
3 itself establish rates and supplementary rate information for one or more market
4 segments based on the factors in s. 625.12 and, if the rates are for motor vehicle
5 liability insurance, subject to s. 632.365, or the insurer may use rates and
6 supplementary rate information prepared by a rate service organization, with
7 average expense factors determined by the rate service organization or with such
8 modification for its own expense and loss experience as the credibility of that
9 experience allows.

10 **SECTION 18.** 628.34 (3) (a) of the statutes is amended to read:

11 628.34 (3) (a) No insurer may unfairly discriminate among policyholders by
12 charging different premiums or by offering different terms of coverage except on the
13 basis of classifications related to the nature and the degree of the risk covered or the
14 expenses involved, subject to ss. 632.365, 632.728, 632.746 and 632.748. Rates are
15 not unfairly discriminatory if they are averaged broadly among persons insured
16 under a group, blanket or franchise policy, and terms are not unfairly discriminatory
17 merely because they are more favorable than in a similar individual policy.

18 **SECTION 19.** 632.728 of the statutes is created to read:

19 **632.728 Coverage of persons with preexisting conditions; guaranteed**
20 **issue. (1) DEFINITIONS.** In this section:

21 (a) “Disability insurance policy” has the meaning given in s. 632.895 (1) (a).

22 (b) “Self-insured health plan” has the meaning given in s. 632.85 (1) (c).

23 **(2) GUARANTEED ISSUE.** Every individual disability insurance policy shall accept
24 every individual and every group disability insurance policy shall accept every
25 employer in this state that applies for coverage, regardless of whether or not any

1 employee or individual has a preexisting condition. A disability insurance policy
2 may restrict enrollment in coverage described in this subsection to open or special
3 enrollment periods.

4 **(3) RATE SETTING AND COST-SHARING DISCRIMINATION PROHIBITED.** For the purpose
5 of setting rates or premiums for coverage under a group or individual disability
6 insurance policy or a self-insured health plan and for the purpose of setting any
7 deductibles, copayments, or coinsurance under a group or individual disability
8 insurance policy or a self-insured health plan, the policy or plan may not consider
9 whether an individual, including a dependent, who would be covered under the plan
10 has a preexisting condition.

11 **(4) SHORT-TERM PLANS.** This section and ss. 632.746 and 632.76 apply to every
12 short-term, limited-duration health insurance policy. In this subsection,
13 “short-term, limited-duration health insurance policy” means health coverage that
14 is provided under a contract with an insurer, has an expiration date specified in the
15 contract that is less than 12 months after the original effective date of the contract,
16 and, taking into account renewals or extensions, has a duration of no longer than 36
17 months in total. “Short-term, limited-duration health insurance policy” includes
18 any short-term policy subject to s. 632.7495 (4).

19 **SECTION 20.** 632.746 (1) (a) of the statutes is renumbered 632.746 (1) and
20 amended to read:

21 632.746 (1) ~~Subject to subs. (2) and (3), an An insurer that offers a group health~~
22 ~~benefit plan may, with respect to a participant or beneficiary under the plan, not~~
23 ~~impose a preexisting condition exclusion only if the exclusion relates to a condition,~~
24 ~~whether physical or mental, regardless of the cause of the condition, for which~~
25 ~~medical advice, diagnosis, care or treatment was recommended or received within~~

1 ~~the 6-month period ending on the participant's or beneficiary's enrollment date~~
2 ~~under the plan on a participant or beneficiary under the plan.~~

3 **SECTION 21.** 632.746 (1) (b) of the statutes is repealed.

4 **SECTION 22.** 632.746 (2) (a) of the statutes is amended to read:

5 632.746 (2) (a) An insurer offering a group health benefit plan may not treat
6 genetic information as a preexisting condition under sub. (1) ~~without a diagnosis of~~
7 ~~a condition related to the information.~~

8 **SECTION 23.** 632.746 (2) (c), (d) and (e) of the statutes are repealed.

9 **SECTION 24.** 632.746 (3) (a) of the statutes is repealed.

10 **SECTION 25.** 632.746 (3) (d) 1. of the statutes is renumbered 632.746 (3) (d).

11 **SECTION 26.** 632.746 (3) (d) 2. and 3. of the statutes are repealed.

12 **SECTION 27.** 632.746 (5) of the statutes is repealed.

13 **SECTION 28.** 632.746 (8) (a) (intro.) of the statutes is amended to read:

14 632.746 (8) (a) (intro.) A health maintenance organization that offers a group
15 health benefit plan ~~and that does not impose any preexisting condition exclusion~~
16 ~~under sub. (1)~~ with respect to a particular coverage option may impose an affiliation
17 period for that coverage option, but only if all of the following apply:

18 **SECTION 29.** 632.76 (2) (a) and (ac) 1. and 2. of the statutes are amended to read:

19 632.76 (2) (a) No claim for loss incurred or disability commencing after 2 years
20 from the date of issue of the policy may be reduced or denied on the ground that a
21 disease or physical condition existed prior to the effective date of coverage, unless the
22 condition was excluded from coverage by name or specific description by a provision
23 effective on the date of loss. This paragraph does not apply to a group health benefit
24 plan, as defined in s. 632.745 (9), which is subject to s. 632.746, a disability insurance

1 policy, as defined in s. 632.895 (1) (a), or a self-insured health plan, as defined in s.
2 632.85 (1) (c).

3 (ac) 1. ~~Notwithstanding par. (a), no~~ No claim or loss incurred or disability
4 commencing after ~~12 months from the date of issue of~~ under an individual disability
5 insurance policy, as defined in s. 632.895 (1) (a), may be reduced or denied on the
6 ground that a disease or physical condition existed prior to the effective date of
7 coverage, ~~unless the condition was excluded from coverage by name or specific~~
8 ~~description by a provision effective on the date of the loss.~~

9 2. ~~Except as provided in subd. 3., an~~ An individual disability insurance policy,
10 as defined in s. 632.895 (1) (a), ~~other than a short-term policy subject to s. 632.7495~~
11 ~~(4) and (5),~~ may not define a preexisting condition more restrictively than a condition,
12 whether physical or mental, regardless of the cause of the condition, for which
13 medical advice, diagnosis, care, or treatment was recommended or received ~~within~~
14 ~~12 months before the effective date of coverage.~~

15 **SECTION 30.** 632.76 (2) (ac) 3. of the statutes is repealed.

16 **SECTION 31.** 632.795 (4) (a) of the statutes is amended to read:

17 632.795 (4) (a) An insurer subject to sub. (2) shall provide coverage under the
18 same policy form and for the same premium as it originally offered in the most recent
19 enrollment period, subject only to the medical underwriting used in that enrollment
20 period. Unless otherwise prescribed by rule, the insurer may apply deductibles,
21 ~~preexisting condition limitations,~~ waiting periods, or other limits only to the extent
22 that they would have been applicable had coverage been extended at the time of the
23 most recent enrollment period and with credit for the satisfaction or partial
24 satisfaction of similar provisions under the liquidated insurer's policy or plan. The
25 insurer may exclude coverage of claims that are payable by a solvent insurer under

1 insolvency coverage required by the commissioner or by the insurance regulator of
2 another jurisdiction. Coverage shall be effective on the date that the liquidated
3 insurer's coverage terminates.

4 **SECTION 32.** 632.883 of the statutes is created to read:

5 **632.883 Lifetime and annual limits. (1)** No group or individual disability
6 insurance policy, as defined in s. 632.895 (1) (a), and no self-insured health plan, as
7 defined in s. 632.745 (24), may impose a lifetime limit on the dollar value of benefits
8 provided under the policy or plan.

9 **(2)** No group or individual disability insurance policy, as defined in s. 632.895
10 (1) (a), and no self-insured health plan, as defined in s. 632.745 (24), may impose an
11 annual limit on the dollar value of benefits under the policy or plan.

12 **SECTION 33.** 632.895 (8) (d) of the statutes is amended to read:

13 632.895 **(8)** (d) Coverage is required under this subsection despite whether the
14 woman shows any symptoms of breast cancer. Except as provided in pars. (b), (c), and
15 (e), coverage under this subsection may only be subject to exclusions and limitations,
16 including deductibles, copayments and restrictions on excessive charges, that are
17 applied to other radiological examinations covered under the disability insurance
18 policy. Coverage under this subsection may not be subject to any deductibles,
19 copayments, or coinsurance.

20 **SECTION 34.** 632.895 (13m) of the statutes is created to read:

21 632.895 **(13m)** PREVENTIVE SERVICES. (a) In this section, "self-insured health
22 plan" has the meaning given in s. 632.85 (1) (c).

23 (b) Every disability insurance policy and every self-insured health plan shall
24 provide coverage for all of the following preventive services:

25 1. Mammography in accordance with sub. (8).

- 1 2. Genetic breast cancer screening and counseling and preventive medication
2 for adult women at high risk for breast cancer.
- 3 3. Papanicolaou test for cancer screening for women 21 years of age or older
4 with an intact cervix.
- 5 4. Human papillomavirus testing for women who have attained the age of 30
6 years but have not attained the age of 66 years.
- 7 5. Colorectal cancer screening in accordance with sub. (16m).
- 8 6. Annual tomography for lung cancer screening for adults who have attained
9 the age of 55 years but have not attained the age of 80 years and who have health
10 histories demonstrating a risk for lung cancer.
- 11 7. Skin cancer screening for individuals who have attained the age of 10 years
12 but have not attained the age of 22 years.
- 13 8. Counseling for skin cancer prevention for adults who have attained the age
14 of 18 years but have not attained the age of 25 years.
- 15 9. Abdominal aortic aneurysm screening for men who have attained the age of
16 65 years but have not attained the age of 75 years and who have ever smoked.
- 17 10. Hypertension screening for adults and blood pressure testing for adults, for
18 children under the age of 3 years who are at high risk for hypertension, and for
19 children 3 years of age or older.
- 20 11. Lipid disorder screening for minors 2 years of age or older, high risk women
21 20 years of age or older, men age 20 years of age or older at high risk for lipid
22 disorders, and all men 35 years of age or older.
- 23 12. Aspirin therapy for cardiovascular health for adults who have attained the
24 age of 55 years but have not attained the age of 80 years and for men who have
25 attained the age of 45 years but have not attained the age of 55 years.

1 13. Behavioral counseling for cardiovascular health for adults who are
2 overweight or obese and who have risk factors for cardiovascular disease.

3 14. Type II diabetes screening for adults with elevated blood pressure.

4 15. Depression screening for minors 11 years of age or older and for adults when
5 follow-up supports are available.

6 16. Hepatitis B screening for minors at high risk for infection and adults at high
7 risk for infection.

8 17. Hepatitis C screening for adults at high risk for infection and one time
9 hepatitis C screening for adults born in 1945 to 1965.

10 18. Obesity screening and management for all minors and adults with a body
11 mass index indicating obesity, counseling and behavioral interventions for obese
12 minors who are 6 years of age or older, and referral for intervention for obesity for
13 adults with a body mass index of 30 kilograms per square meter or higher.

14 19. Osteoporosis screening for all women 65 years of age or older and for women
15 at high risk for osteoporosis under the age of 65 years.

16 20. Immunizations in accordance with sub. (14).

17 21. Anemia screening for individuals 6 months of age or older and iron
18 supplements for individuals at high risk for anemia and who have attained the age
19 of 6 months but have not attained the age of 12 months.

20 22. Fluoride varnish for prevention of tooth decay for minors at the age of
21 eruption of their primary teeth.

22 23. Fluoride supplements for prevention of tooth decay for minors 6 months of
23 age or older who do not have fluoride in their water source.

24 24. Gonorrhea prophylaxis treatment for newborns.

25 25. Health history and physical exams for prenatal visits and for minors.

- 1 26. Length and weight measurements for newborns and height and weight
2 measurements for minors.
- 3 27. Head circumference and weight for length measurements for newborns and
4 minors who have not attained the age of 3 years.
- 5 28. Body mass index for minors 2 years of age or older.
- 6 29. Blood pressure measurements for minors 3 years of age or older and a blood
7 pressure risk assessment at birth.
- 8 30. Risk assessment and referral for oral health issues for minors who have
9 attained the age of 6 months but have not attained the age of 7 years.
- 10 31. Blood screening for newborns and minors who have not attained age 2
11 months.
- 12 32. Screening for critical congenital health defect for newborns.
- 13 33. Lead screenings in accordance with sub. (10).
- 14 34. Metabolic and hemoglobin screening and screening for phenylketonuria,
15 sickle cell anemia, and congenital hypothyroidism for minors including newborns.
- 16 35. Tuberculin skin test based on risk assessment for minors one month of age
17 or older.
- 18 36. Tobacco counseling and cessation interventions for individuals who are 5
19 years of age or older.
- 20 37. Vision and hearing screening and assessment for minors including
21 newborns.
- 22 38. Sexually transmitted infection and human immunodeficiency virus
23 counseling for sexually active minors.

1 39. Risk assessment for sexually transmitted infection for minors who are 10
2 years of age or older and screening for sexually transmitted infection for minors who
3 are 16 years of age or older.

4 40. Alcohol misuse screening and counseling for minors 11 years of age or older.

5 41. Autism screening for minors who have attained the age of 18 months but
6 have not attained the age of 25 months.

7 42. Developmental screening and surveillance for minors including newborns.

8 43. Psychosocial and behavioral assessment for minors including newborns.

9 44. Alcohol misuse screening and counseling for pregnant adults and a risk
10 assessment for all adults.

11 45. Fall prevention and counseling and preventive medication for fall
12 prevention for community-dwelling adults 65 years of age or older.

13 46. Screening and counseling for intimate partner violence for adult women.

14 47. Well-woman visits for women who have attained the age of 18 years but
15 have not attained the age of 65 years and well-woman visits for recommended
16 preventive services, preconception care, and prenatal care.

17 48. Counseling on, consultations with a trained provider on, and equipment
18 rental for breastfeeding for pregnant and lactating women.

19 49. Folic acid supplement for adult women with reproductive capacity.

20 50. Iron deficiency anemia screening for pregnant and lactating women.

21 51. Preeclampsia preventive medicine for pregnant adult women at high risk
22 for preeclampsia.

23 52. Low-dose aspirin after 12 weeks of gestation for pregnant women at high
24 risk for miscarriage, preeclampsia, or clotting disorders.

25 53. Screenings for hepatitis B and bacteriuria for pregnant women.

1 54. Screening for gonorrhea for pregnant and sexually active females 24 years
2 of age or younger and females older than 24 years of age who are at risk for infection.

3 55. Screening for chlamydia for pregnant and sexually active females 24 years
4 of age and younger and females older than 24 years of age who are at risk for
5 infection.

6 56. Screening for syphilis for pregnant women and adults who are at high risk
7 for infection.

8 57. Human immunodeficiency virus screening for adults who have attained the
9 age of 15 years but have not attained the age of 66 years and individuals at high risk
10 of infection who are younger than 15 years of age or older than 65 years of age.

11 58. All contraceptives and services in accordance with sub. (17).

12 59. Any services not already specified under this paragraph having an A or B
13 rating in current recommendations from the U.S. Preventive Services Task Force.

14 60. Any preventive services not already specified under this paragraph that are
15 recommended by the federal health resources and services administration's Bright
16 Futures project.

17 61. Any immunizations, not already specified under sub. (14), that are
18 recommended and determined to be for routine use by the Advisory Committee on
19 Immunization Practices.

20 (c) Subject to par. (d), no disability insurance policy and no self-insured health
21 plan may subject the coverage of any of the preventive services under par. (b) to any
22 deductibles, copayments, or coinsurance under the policy or plan.

23 (d) 1. If an office visit and a preventive service specified under par. (b) are billed
24 separately by the health care provider, the disability insurance policy or self-insured

1 health plan may apply deductibles to and impose copayments or coinsurance on the
2 office visit but not on the preventive service.

3 2. If the primary reason for an office visit is not to obtain a preventive service,
4 the disability insurance policy or self-insured health plan may apply deductibles to
5 and impose copayments or coinsurance on the office visit.

6 3. If a preventive service specified under par. (b) is provided by a health care
7 provider that is outside the disability insurance policy's or self-insured health plan's
8 network of providers, the policy or plan may apply deductibles to and impose
9 copayments or coinsurance on the office visit and the preventive service. If a
10 preventive service specified under par. (b) is provided by a health care provider that
11 is outside the disability insurance policy's or self-insured health plan's network of
12 providers because there is no available health care provider in the policy's or plan's
13 network of providers that provides the preventive service, the policy or plan may not
14 apply deductibles to or impose copayments or coinsurance on preventive service.

15 4. If multiple well-woman visits described under par. (b) 47. are required to
16 fulfill all necessary preventive services and are in accordance with clinical
17 recommendations, the disability insurance policy or self-insured health plan may
18 not apply a deductible or impose a copayment or coinsurance to any of those
19 well-woman visits.

20 **SECTION 35.** 632.895 (14) (a) 1. i. and j. of the statutes are amended to read:

21 632.895 (14) (a) 1. i. Hepatitis A and B.

22 j. Varicella and herpes zoster.

23 **SECTION 36.** 632.895 (14) (a) 1. k. to o. of the statutes are created to read:

24 632.895 (14) (a) 1. k. Human papillomavirus.

25 L. Meningococcal meningitis.

1 m. Pneumococcal pneumonia.

2 n. Influenza.

3 o. Rotavirus.

4 **SECTION 37.** 632.895 (14) (b) of the statutes is amended to read:

5 632.895 (14) (b) Except as provided in par. (d), every disability insurance policy,
6 and every self-insured health plan of the state or a county, city, town, village, or
7 school district, ~~that provides coverage for a dependent of the insured~~ shall provide
8 coverage of appropriate and necessary immunizations, ~~from birth to the age of 6~~
9 ~~years, for an insured or plan participant, including a dependent who is a child of the~~
10 ~~insured or plan participant.~~

11 **SECTION 38.** 632.895 (14) (c) of the statutes is amended to read:

12 632.895 (14) (c) The coverage required under par. (b) may not be subject to any
13 deductibles, copayments, or coinsurance under the policy or plan. ~~This paragraph~~
14 ~~applies to a defined network plan, as defined in s. 609.01 (1b), only with respect to~~
15 ~~appropriate and necessary immunizations provided by providers participating, as~~
16 ~~defined in s. 609.01 (3m), in the plan.~~

17 **SECTION 39.** 632.895 (14) (d) 3. of the statutes is amended to read:

18 632.895 (14) (d) 3. A health care plan offered by a limited service health
19 organization, as defined in s. 609.01 (3), ~~or by a preferred provider plan, as defined~~
20 ~~in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).~~

21 **SECTION 40.** 632.895 (14m) of the statutes is created to read:

22 632.895 (14m) ESSENTIAL HEALTH BENEFITS. (a) In this section, “self-insured
23 health plan” has the meaning given in s. 632.85 (1) (c).

1 (b) On a date specified by the commissioner, by rule, every disability insurance
2 policy and every self-insured health plan shall provide coverage for essential health
3 benefits as determined by the commissioner, by rule, subject to par. (c).

4 (c) In determining the essential health benefits for which coverage is required
5 under par. (b), the commissioner shall do all of the following:

6 1. Include benefits, items, and services in, at least, all of the following
7 categories:

8 a. Ambulatory patient services.

9 b. Emergency services.

10 c. Hospitalization.

11 d. Maternity and newborn care.

12 e. Mental health and substance use disorder services, including behavioral
13 health treatment.

14 f. Prescription drugs.

15 g. Rehabilitative and habilitative services and devices.

16 h. Laboratory services.

17 i. Preventive and wellness services and chronic disease management.

18 j. Pediatric services, including oral and vision care.

19 2. Conduct a survey of employer-sponsored coverage to determine benefits
20 typically covered by employers and ensure that the scope of essential health benefits
21 for which coverage is required under this subsection is equal to the scope of benefits
22 covered under a typical disability insurance policy offered by an employer to its
23 employees.

24 3. Ensure that essential health benefits reflect a balance among the categories
25 described in subd. 1. such that benefits are not unduly weighted toward one category.

1 4. Ensure that essential health benefit coverage is provided with no or limited
2 cost-sharing requirements.

3 5. Require that disability insurance policies and self-insured health plans do
4 not make coverage decisions, determine reimbursement rates, establish incentive
5 programs, or design benefits in ways that discriminate against individuals because
6 of their age, disability, or expected length of life.

7 6. Establish essential health benefits in a way that takes account of the health
8 care needs of diverse segments of the population, including women, children, persons
9 with disabilities, and other groups.

10 7. Ensure that essential health benefits established under this subsection not
11 be subject to a coverage denial based on an insured's or plan participant's age,
12 expected length of life, present or predicted disability, degree of dependency on
13 medical care, or quality of life.

14 8. Require that disability insurance policies and self-insured health plans
15 cover emergency department services that are essential health benefits without
16 imposing any requirement to obtain prior authorization for those services and
17 without limiting coverage for services provided by an emergency services provider
18 that is not in the provider network of a policy or plan in a way that is more restrictive
19 than requirements or limitations that apply to emergency services provided by a
20 provider that is in the provider network of the policy or plan.

21 9. Require a disability insurance policy or self-insured health plan to apply to
22 emergency department services that are essential health benefits provided by an
23 emergency department provider that is not in the provider network of the policy or
24 plan the same copayment amount or coinsurance rate that applies if those services
25 are provided by a provider that is in the provider network of the policy or plan.

1 (d) The commissioner shall periodically update, by rule, the essential health
2 benefits under this subsection to address any gaps in access to coverage.

3 (e) If an essential health benefit is also subject to mandated coverage elsewhere
4 under this section and the coverage requirements are not identical, the disability
5 insurance policy or self-insured health plan shall provide coverage under whichever
6 subsection provides the insured or plan participant with more comprehensive
7 coverage of the medical condition, item, or service.

8 (f) Nothing in this subsection or rules promulgated under this subsection
9 prohibits a disability insurance policy or a self-insured health plan from providing
10 benefits in excess of the essential health benefit coverage required under this
11 subsection.

12 **SECTION 41.** 632.895 (16m) (b) of the statutes is amended to read:

13 632.895 (**16m**) (b) The coverage required under this subsection may be subject
14 to any limitations, or exclusions, ~~or cost-sharing provisions~~ that apply generally
15 under the disability insurance policy or self-insured health plan. The coverage
16 required under this subsection may not be subject to any deductibles, copayments,
17 or coinsurance.

18 **SECTION 42.** 632.895 (17) (b) 2. of the statutes is amended to read:

19 632.895 (**17**) (b) 2. Outpatient consultations, examinations, procedures, and
20 medical services that are necessary to prescribe, administer, maintain, or remove a
21 contraceptive, ~~if covered for any other drug benefits under the policy or plan~~
22 sterilization procedures, and patient education and counseling for all females with
23 reproductive capacity.

24 **SECTION 43.** 632.895 (17) (c) of the statutes is amended to read:

1 632.895 (17) (c) Coverage under par. (b) may be subject only to the exclusions,
2 and limitations, or cost-sharing provisions that apply generally to the coverage of
3 outpatient health care services, preventive treatments and services, or prescription
4 drugs and devices that is provided under the policy or self-insured health plan. A
5 disability insurance policy or self-insured health plan may not apply a deductible or
6 impose a copayment or coinsurance to at least one of each type of contraceptive
7 method approved by the federal food and drug administration for which coverage is
8 required under this subsection. The disability insurance policy or self-insured
9 health plan may apply reasonable medical management to a method of contraception
10 to limit coverage under this subsection that is provided without being subject to a
11 deductible, copayment, or coinsurance to prescription drugs without a brand name.
12 The disability insurance policy or self-insured health plan may apply a deductible
13 or impose a copayment or coinsurance for coverage of a contraceptive that is
14 prescribed for a medical need if the services for the medical need would otherwise be
15 subject to a deductible, copayment, or coinsurance.

16 **SECTION 44.** 632.897 (11) (a) of the statutes is amended to read:

17 632.897 (11) (a) Notwithstanding subs. (2) to (10), the commissioner may
18 promulgate rules establishing standards requiring insurers to provide continuation
19 of coverage for any individual covered at any time under a group policy who is a
20 terminated insured or an eligible individual under any federal program that
21 provides for a federal premium subsidy for individuals covered under continuation
22 of coverage under a group policy, including rules governing election or extension of
23 election periods, notice, rates, premiums, premium payment, ~~application of~~
24 ~~preexisting condition exclusions~~, election of alternative coverage, and status as an
25 eligible individual, as defined in s. 149.10 (2t), 2011 stats.

